State of North Dakota
Workforce Safety & Insurance

2008 Performance Evaluation Report

October 8, 2008

BERRY.DUNN.MCNEIL & PARKER

BDMP

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October 8, 2008

Governor of North Dakota
The Legislative Assembly
Chairman of the Board of Directors, Workforce Safety & Insurance
Executive Director, Workforce Safety & Insurance

We are pleased to submit this report summarizing the results of the 2008 Performance Evaluation of North Dakota's Workforce Safety & Insurance (WSI) which covers Calendar Years 2006 and 2007. The purpose of this evaluation was to assess certain aspects of the functions and operations of WSI as directed by the Office of the State Auditor and in accordance with North Dakota Century Code Section 65-02-30

This 2008 Performance Evaluation addresses the following nine elements:

- **Element 1**: Evaluation of Safety Grants;
- **Element 2**: Board of Directors Evaluation;
- **Element 3**: Evaluation of Performance Measures;
- **Element 4**: Evaluation of Fraud Expenditures;
- **Element 5**: Evaluation of Prior Performance Evaluation Recommendations;
- **Element 6**: Claims;
- **Element 7**: Evaluation of the Change in Financial Condition from FY 1997 - FY 2007;
- **Element 8**: Policy Holder Services; and,
- **Element 9**: Legal.

Where applicable, BDMP has provided recommendations pertaining to each of the elements.

This evaluation includes the executive summary, detailed sections for each element including relevant recommendations, WSI responses to BDMP's recommendations, and supporting appendices as warranted. In some instances, we have added follow-up comments to WSI responses.

We wish to thank all those at WSI who assisted us in the performance evaluation process.

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State of North Dakota

Workforce Safety & Insurance

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Executive Summary

Introduction

In the spring of 2008, the State of North Dakota engaged Berry Dunn McNeil & Parker (BDMP) to conduct a performance evaluation of certain components of the North Dakota Workforce Safety & Insurance organization (WSI). The overall objective of this evaluation was to determine whether WSI is providing quality service in an efficient and cost-effective manner, and to provide recommendations for improvement.

BDMP's performance evaluation considered the following elements as specified by the Office of the State Auditor:

- Safety Grants
- Board of Directors
- Performance Measures maintained by WSI
- Effectiveness of Fraud Expenditures
- Prior Performance Evaluation Recommendations
- Claims
- Change in Financial Condition of WSI
- Policyholder Services
- Legal and the Administrative Hearing Process

Our evaluation team included specialists in workers compensation, actuarial practices, accounting, board governance, and business operations. Each element was evaluated by one or more members of our team who led the fact finding portion for their assigned elements. At the conclusion of these evaluations, our entire team collaborated to analyze the element data and to develop recommendations.

We identified 46 recommendations for improvement as a result of our work. Our conclusions and recommendations are described at a high level in the following paragraphs of this Executive Summary. Because this is only a summary, we caution readers that they should read and understand the full report before drawing conclusions or taking any actions.

Results

The following paragraphs are organized by review element and present highlights of our findings, conclusions, and recommendations:

Element 1 - Safety Grants

BDMP's evaluation of WSI and of benchmark systems in other states shows that safety Grant programs serve a useful purpose. WSI has an opportunity to improve the current safety grant program by creating a process that is more open and interactive with the employer and the worker community it supports; by improving the consistency and credibility of the award and intervention verification process; and by designing and staffing the outcome measurement function appropriately.

Inconsistencies were identified in the safety grant review and those are described in the observations and findings of this report. In order to improve public confidence and the effectiveness of the safety grant award program, WSI should:

- Create an advisory committee to assist in the design and implementation of needed safety grant programs
- Engage employer and employee constituencies in the development of grant eligibility, applications, and decision making processes
- More actively market the STEP grant program
- Implement a redesigned HELP safety grant program
- Determine how grant programs will be measured prior to the awarding of funds

Element 2 - Board of Directors

BDMP evaluated the WSI board governance model in place at WSI during the evaluation period and found that the WSI Board complied with its governance policies. Additionally, we considered WSI's current governance model and policies and determined they are appropriate for WSI.

In this report we have identified recommendations that will strengthen the makeup, operation, and functioning of the board and will also clarify the roles and responsibilities of board members. These recommendations include:

- Modifying criteria used to appoint board members to include specific skills and experience relevant to a state workers' compensation fund specifically, in the area of accounting and actuarial disciplines

- Reviewing and clarifying the process with respect to board member qualifications so as to serve the State statute

- Filling the Internal Audit Manager position and giving this person appropriate board support to effectively perform the function

Element 3 - Performance Measures

BDMP's evaluation of the performance measures maintained by WSI revealed no significant issues with the accuracy of the metrics currently used in Operating Reports with respect to claims and financial data. We did observe, however, unreconciled differences in information reported with respect to Legal/SIU data. We also observed that WSI tracks many more measures than other peer organizations. While the metrics in the WSI Operating Report are valid, many of them are more appropriate for use at a department level rather than for overall governance and decision-making at the board level.

The effectiveness of WSI's use of performance metrics could be improved by:

- Focusing the Board's attention on a smaller number (15 to 25) of strategic measurements

- Providing more training and support for board members

- Periodically benchmarking WSI performance against national standards

- Strengthening the transparency of changes to reports

- Making better use of automation in generating reports

- Having the internal audit department review information provided by the SIU department

Element 4 - Effectiveness of Fraud Expenditures

BDMP evaluated WSI's fraud expenditures and concluded that WSI's Special Investigative Unit (SIU) appears inadequately resourced and positioned to fulfill its fraud prevention and investigation function. WSI does not have a comprehensive employer and provider fraud program in place to protect the best interests of legitimate employers and workers. We also noted a history of inter-departmental conflict and role confusion between former directors of

SIU and Policyholder Services that has made it difficult to support a comprehensive fraud program.

Fraud identification, investigation, and prevention are critical responsibilities of WSI management when protecting the interests of stakeholders. We have made recommendations that will help WSI management to:

- Clearly define fraud prevention roles and responsibilities
- Increase focus on conducting provider and employer fraud investigations
- Strengthen collaboration between internal and external organizations to more proactively identify and investigate fraud
- Strengthen training for fraud investigators and timely follow-up with respect to complaints received
- Track the costs and benefits of fraud activities in order to demonstrate long-term value

Element 5 – Previous Performance Evaluation Recommendations

WSI tracked the implementation status of 109 prior recommendations from the 2006 Performance Evaluation. In our work, BDMP identified that 61 (56%) of these recommendations have been fully implemented. The remainder are either partially implemented or, as the result of WSI management decision, not implemented. The Element 5 section of this report and Appendix C provide detailed information on our findings.

Going forward, WSI should improve their tracking of prior recommendations by requiring that recommendations be classified as "100% complete" only after Internal Audit has completed an independent validation of actions and assessed final disposition of the recommendations

Element 6 - Claims

BDMP independently evaluated a random and objective sample of 250 claims, including denied claims, claims referred to Independent Medical Exams (IME's), and claims for people with degenerative conditions. In our work we found no evidence of inappropriate claims handling processes or of decisions inconsistent with State law or WSI claim policies. The claims handling displayed in the files we evaluated was appropriate.

We identified impacts on claims processing related to a change in philosophy that occurred during 2006-2007 in which adjusters were encouraged to investigate all new claims for prior injuries or pre-existing conditions more thoroughly. Multiple factors, including the change in philosophy and practices to incentivize prompt claim submission did result in increased rates of

denied claims. However, none of the claims evaluated were denied inappropriately based on state law, administrative code, and WSI claim policies.

Our recommendations with respect to claims include:

- Revising the WSI Claim Procedure Manual to standardize "best practices" and train claims adjusters on new practices
- Implementing the Injury Management pilot program across all 7 claim units
- Enhancing WSI's knowledge of industry best practices through attendance at appropriate industry conferences
- Reviewing the North Dakota Statute in relation to other jurisdictions

In our work, BDMP observed that the North Dakota Statute is more conservative than most other jurisdictions with respect to treatment for specific conditions. Bringing together North Dakota stakeholder groups to study and consider how other states handle such conditions and choosing what is appropriate for the State of North Dakota, will be beneficial to the employers, injured workers, and WSI.

Element 7 - Change in Financial Condition, FY 1997-FY2007

BDMP evaluated the change in WSI's financial condition from FY1997 through FY2007. Our analysis identified that the greatest impact on increasing the financial reserves has been WSI conservative approach to investment assumptions. We identified the following factors that impacted WSI's financial condition, ranked in order of descending impact from greatest to least:

- Investment return in excess of assumed rate of return
- Reduction in the discount rate used for employer rate setting
- Discount rates for unpaid loss liability
- Additional revenue from other sources
- Changes in the undiscounted estimated claims expenses
- Change in economic conditions in the State of North Dakota

WSI Board members and stakeholders should understand the nature of these factors and consider their impact in making decisions for WSI.

In our work, BDMP considered the change in structure from reporting to the Governor to reporting to a Board of Directors. We did not identify a direct or indirect correlation between the change in reporting structure and the change in financial condition.

Element 8 - Policyholder Services

BDMP evaluated employer rates, employee classifications, and the Policyholder Services Division audit plan for the evaluation period. From this analysis, we did not identify any employer rates or employee classifications that were inconsistently applied or inappropriate. We noted that WSI is appropriately focusing its premium audit efforts on the significant policyholders where potential audit adjustments could yield a more significant result.

Our recommendations for WSI with respect to policyholder services include:

- Reviewing the premium audit function and determining whether additional staffing is necessary in order to comply with the stated audit plan
- Adopting a process that allocates policyholder dividends to active policyholders based on historical information
- Seeking to modify the appropriate section of North Dakota statute to reduce the lower end of the required fund surplus range to 115% of the discounted loss reserves plus surplus

Element 9 - Legal

BDMP's evaluation of North Dakota's workers' compensation administrative hearing process revealed that the process is efficient, however, it is not effective for the workers of North Dakota. We found no indication of impropriety or inappropriate influence on decisions.

The perception of fairness and overall effectiveness of the system relates to the situation where North Dakota is the only jurisdiction in the United States where the payer (WSI) makes the final administrative decision in disputes between payers and injured workers. This situation would be improved by separating independent fact finder responsibilities from WSI.

Our recommendations with respect to this element are:

- WSI and the State of North Dakota should seek legislative changes such that administrative decisions are made by an independent, impartial hearing authority from a government agency separate from WSI.
- WSI should train administrate law judges or hearing officers using national practices and external experts in North Dakota-specific workers compensation and administrative law.

Organization and Structure of this Report

This report is structured into nine sections, one for each element for our review. Within each element, our report is organized as follows:

- ***Objective*** – States the focal points of each element in the performance evaluation. In some cases an element has multiple components, and these are presented in bulleted lists.

- ***Key Activities*** – Describes the approaches and work on which our findings, conclusions, and recommendations are based.

- ***Observations and Findings*** – Presents key information on which our analyses and conclusions are based.

- ***Conclusions*** – Presents the determinations we drew from our fact-finding and analysis.

- ***Recommendations*** – Presents and describes the recommendations for improvement which we developed as a result of our evaluations.

In some instances, sections have been combined for readability and flow of information. Also, some sections include "background" information to provide historical context of that element for the reader.

For each element, we have presented and described recommendations at the end of the appropriate element section. This is done for purposes of consistency and because, in some instances, multiple observations and findings led to the same recommendation. To facilitate the reader's review of this report, we have provided references within each element's observations and findings to relevant recommendations.

We have prioritized each of our recommendations with respect to High, Medium, or Low priority. The priority rankings are assigned based on our professional experience, objective assessment as to the risk or benefit at the time of our evaluation, and relative comparison between our recommendations. These are described as follows:

- High – Issue presents an immediate significant risk or benefit to the organization and immediate action should be taken to resolve the issue or realize the benefit. Risk is broadly defined to include but not be limited to: financial, political or legal.

- Medium – Issue presents a lower level of risk that may not pose an immediate threat or a benefit that will be achieved right away, but should be addressed by WSI in the near term.

- Low – Comments that are more administrative in nature that represent a less significant level of risk or benefit. Implementation of these comments would enhance the current systems in place at WSI.

Our Performance Evaluation

The period of evaluation for this performance evaluation was January 1, 2006 through December 31, 2007. Our work was conducted from April through June of 2008.

Our work was conducted in accordance with the instructions and parameters set forth in the Request for Proposal #117-08-01 issued by the State of North Dakota Office of the State Auditor. The work performed by us in conducting this performance evaluation does not constitute an audit as defined by the American Institute of Certified Public Accountants, nor does it in any way constitute a legal review.

In several components of our work we have relied upon audits and other reports prepared for WSI or the State of North Dakota. Where we have done so, this is presented in the Key Activities section of each element of our report.

Closing Remarks

Readers should note that reports of this type, by their very nature, focus on areas for improvement and typically do not comment to the same extent on areas of strength that we observed.

We wish to acknowledge and thank the staff of WSI for the cooperation and courtesy exhibited while conducting our evaluation.

Element 1: Safety Grants

Objectives

Element One required a complete review of the safety grants awarded by the agency. This review included four components:

1. An evaluation of the criteria used to award grants;
2. The consistency of application of the criteria in the review process;
3. An evaluation of the effectiveness of the safety grant program; and
4. A comparison to other safety programs implemented by monopolistic states and large insurance companies regarded as industry leaders specializing in providing workers' compensation insurance.

Key Activities

BDMP performed the following activities to gather information about the STEP 1, STEP 2, and HELP safety award grant programs:

1. Reviewed North Dakota statute and rules pertaining to the safety grants;
2. Reviewed applications and procedures used by staff in reviewing and accepting or denying grant applications;
3. Reviewed publicly available information about the safety grant programs on the WSI website;
4. Reviewed previous audit reports, including one of the HELP grant program conducted by the agency Internal Auditor dated July 11, 2007;
5. Conducted interviews with current and past WSI employees, including the current and previous safety grant coordinator; the VP of Strategic Operations and the previous Employer Services Chief; the manager of Policyholder Services; and the supervisor of Special Programs;
6. Visited and interviewed two grant awardees;
7. Reviewed seven STEP grant files and 38 HELP grant files to determine the grant review process and the consistency with which this was followed;

8. Surveyed 55 grant applicants whose grants were denied to determine the level of communication and satisfaction with the process and with the explanation they were given regarding their grant denial (received 28 responses – 51% response rate); and

9. Reviewed and compared safety grant programs in British Columbia, Minnesota, Oregon, Ohio, Washington, Wisconsin and Wyoming; as well as the National Institute of Safety and Health (NIOSH), to benchmark WSI's program and to determine if there are other models that may be of benefit to North Dakota in their upcoming revisions of the grant programs.

Background

North Dakota statute 65-03-04 authorizes WSI "...**to create and operate work safety and loss prevention programs to protect the health of covered employees and the financial integrity of the fund**, including programs promoting safety practices by employers and employees through education, training, consultation, grants, or incentives." (Emphasis Added) It also authorizes a continuing appropriation for this purpose.

WSI promulgated administrative rules for the grant programs under Chapter 92-05-03 entitled "Grant Programs," the most recent of which was effective July 1, 2006 (with one amendment effective July 1, 2007). This rule provides broad authority to WSI to create matching grant programs for North Dakota employers to fund safety interventions or develop other programs to reduce workplace injury and illness. Eligibility requirements within the rule limit the grant applications to North Dakota-based employers who have an active employer account. Applicants must demonstrate a need for money pursuant to the terms of the grant application. Grant award authority rests solely within the discretion of WSI under these rules with the only requirement for WSI being that a grant review board be established and that any grants awarded be subject to a signed agreement.

To support the legislative intent in 65-03-04, the Governing Board of WSI issued a policy (revised as of May, 2006) to "continue to develop and expand proactive safety programs" and made $35 million available for the safety grant programs. There were four safety grant programs in effect between 2005 and 2007, the previously referenced STEP 1 and STEP 2 grants and the HELP grant. (Previously, the Safety Partnership Grant Program was in place, but this ending in July 2005.) WSI spent a total of $3,946,739 on grants during the biennium, approximately 11% of the funds for safety programs.

Taken as a whole, the intent of the safety grant programs administered by WSI is to reduce injuries and illnesses to North Dakotans by increasing the level of safety education and training, and also by investing in and evaluating the effectiveness of the use of specific safety interventions. These interventions are designed to minimize or eliminate known hazards that result in work-related injuries to covered employees, and therefore reduce future expenditures for WSI.

Three safety grants programs were evaluated as part of this review, STEP 1, STEP 2 and HELP:

- Safety Training and Education Program (STEP) 1 and 2 – The STEP 1 and STEP 2 safety grant programs began in July 2006 and are one-year grants to promote safety practices through safety training and education. The programs seek to enlist the resources of North Dakota associations and employee organizations to assist in reducing injuries and accidents. The STEP 1 grant funds projects from $5,000 to $25,000; the STEP 2 grant funds projects from $25,001 to $150,000 and will pay for salaries, benefits, and other expenses that a STEP 1 grant does not authorize.

- Hazard Elimination Learning Program (HELP) – The HELP grant program began in January of 2006 and is designed to provide economic assistance to improve worker safety and conduct research regarding the effectiveness of each specific safety intervention funded. The research is intended to be shared with other employees in order to provide them with a clear picture of the effectiveness of specific safety interventions.

  Due to concerns about the effectiveness of the program, WSI stopped taking applications on October 15, 2007, and has indicated plans to modify and re-implement the program at a later date. These concerns are detailed in a policy paper dated November 1 2007 and include a concern about the resource implications and WSI's ability to obtain useful data upon which to evaluate the program's effectiveness. Recommendations also included in that paper included: generating more useful research data upon which to evaluate the program; to move away from the current survey practice; and to raise the amount invested by the employer.

Observations and Findings

Objective 1: Evaluation of Criteria Used

BDMP evaluated the STEP and the HELP grant programs by utilizing a criteria list compiled from State statutes NDCC 92-05-02 and NDCC 92-05-03; the WSI Grant Guidelines instructions; and the grant evaluation forms used by the grant review board.

For the evaluation period, WSI awarded two STEP 1 grants and five STEP 2 grants. One STEP 2 grant was denied. BDMP reviewed a total of five (63%) STEP applications for compliance with award criteria.

WSI received over 500 HELP grant applications between July and October 2007. Of these, approximately 330 were received by October 1, 2007, with the remaining submitted by the program's formal close on October 15, 2007. BDMP reviewed 33 HELP grants from those applications received by October 1, 2007 and six grants from those received between October 1 and October 15, 2007.

We found the evaluation criteria to be appropriate overall and consistent with the statute and applicable rules for both programs, but ineffective for purposes of evaluating the results of these programs in preventing injuries. (See Recommendations 1.4, 1.5 and 1.6)

Objective 2: Evaluation of Consistency of Criteria Application

The objective of our review was to determine if the established selection criteria were appropriately and consistently applied to award grants.

In our review, we noted inconsistencies that may be improper or may create the appearance of inappropriate application of the award criteria. These inconsistencies included:

- *A commitment of funds prior to the existence of an appropriate grant program to fund such commitment*. BDMP learned about one instance where the prior WSI CEO made a financial commitment to an organization for safety grant funds prior to a formal application and review being completed. WSI staff identified this, brought it to the attention of legal services, and no grant was awarded until the organization involved submitted an application and it went through the formal review process. The initial commitment was for up to $150,000 and was noted in a letter dated March 1, 2007. Staff requested a grant application submission once the program was in place and after a consideration by the review board, a one-year grant of $79,207.47 was awarded on August 28, 2007. BDMP's evaluation did not include a legal review. This issue may warrant further evaluation to determine if any law, rules or regulations were violated.

- *Lack of documentation proving eligibility*. A grant application package that we observed lacked a listing of members who would be served by the STEP 2 grant, as is required in the criteria. (Note that there were only four STEP 2 grants awarded at time of the review, and one reviewed - 25% did not have a current listing of members in the file). (See Recommendation 1.4)

- *Inconsistent use of grant evaluation documentation*. This included partially completed forms and unattributed deletions and corrected ratings. The review board-generated evaluation sheets did not often provide a clear rationale for the scores being given. Although this is not required by the rules and guidelines given to applicants, these deficiencies make it difficult to determine how the evaluators calculated their scores. (See Recommendation 1.4)

In the review of HELP applications and awards, we noted process inconsistencies that may create an appearance of inappropriate application of the award criteria. BDMP did note some issues that could create the perception of impropriety and if addressed, could strengthen the management of the program. These included:

- *Verification of grading process*. WSI Internal Auditors previously identified grant grading sheets that were incorrectly calculated. Process improvements have been implemented to correct this problem and no such problems were found in grants reviewed that were awarded since this process improvement was implemented. However, in at least 45% of the HELP grants reviewed rating scores on evaluation sheets were crossed out and replaced with corrected ratings. In all cases these new ratings were only slightly different from the previous ratings and in no instances would the resulting scores have changed the grant award decision. However, WSI should require evaluators to initial any changes in scores, in order to document that changes were made by them and therefore do not violate the process. (See Recommendation 1.4)

- *Lack of a process for changing grant criteria*. WSI has implemented grant criteria changes in a manner that is not sufficiently transparent and open to public review. An example of this was the policy of whether an applicant had to submit a separate application for each funding request, or if they could include multiple requests on one application. Initially the policy was one intervention per application. However, after receiving a complaint from a policyholder, WSI changed its policy without public notice. Changes to grant criteria such as this create an impression of inappropriate bias and/or the absence of an objective review process. (See Recommendation 1.2)

Objective 3: Evaluation of the Effectiveness of the Safety Grant Programs

The creation and administration of safety grant programs is an effective way for WSI to assist workers in obtaining needed safety equipment, materials, training, and education. Programs such as these exist in two of the other three monopolistic state funds (Ohio's Safety Intervention Program and Washington's Safety and Health Investments Grants Program), as well as in other recognized worker protection programs such as those in Massachusetts, Michigan, Minnesota, Oregon, Wisconsin, the federal National Institute of Occupational Safety and Health (NIOSH) and in the Canadian monopolistic workers compensation funds.

Although not mentioned in detail within this report, BDMP did review the intervention payment process and found it sufficient to document that the grantee actually purchased the intervention being funded. The WSI payment process requires an actual receipt be presented for the intervention before WSI reimburses the grantee for the equipment. Additionally, the process includes a verification that the equipment was in use by a WSI safety professional during an on-site visit after the grant payment. However, in only 24 of the 42 grant files reviewed was their documentation that the safety professional visit had been made at the time that we received the files. (See Recommendation 1.7)

BDMP noted one case where a policyholder submitted three applications for interventions which exceeded the $50,000 lifetime limit for funds. The actual grant award files documented awards of only $50,000 but the actual payments exceeded that amount due apparently to an accounting error. The process the grant coordinator uses to check and verify WSI payments

would have caught this overpayment on the 15th of the subsequent month. At the time of the review, the policyholder was returning the check for reissuance in the proper amount.

BDMP evaluated the effectiveness of these programs by:

1. Determining if the programs were perceived by North Dakota employers as being accessible, being administered fairly, and making appropriate use of employer funds;

2. Determining if the programs were achieving the desired outcomes that were defined for each of the grant programs; and

3. Determining whether the North Dakota incident rates had decreased by the WSI stated goal of 10% during the biennium.

Given that the STEP program began in July 2006 and the HELP program in January, 2006, a true evaluation of the effectiveness of these programs is premature. However, given the results of interviews, grant file reviews, and surveys conducted by WSI and BDMP, the following facts are currently available to make preliminary determinations about the effectiveness of WSI's safety grant programs:

- *Publicity of grant programs*. The HELP program has received more publicity than the STEP program. Information about the HELP program is posted on the WSI website and advertised in various industry publications. In addition, presentations on the HELP program were made to several safety groups. Publicity of the STEP program is limited to a single page on WSI's website which provides little information about the program. In order to provide applicants with adequate information to understand and respond to the STEP program, additional targeted publicity is warranted. (See Recommendation 1.3)

- *Analysis of grant results*. BDMP conducted a face-to-face interview with one of the STEP 2 grant recipients (there are only a total of four) to determine what results they had achieved from their grant award. It appeared that their STEP 2 grant was actually a continuation of grants that had been awarded under the previous Safety Partnership Program. They were able to document significant reductions in incident rates for the entire association through its "partnership" with WSI.

  This partnership began in 1999 when WSI made an investment of $170,000 for the bienniums from 1999 to June of 2005, which became an annual figure of $65,000 starting in July of 2005 and has continued at that level each year. They acknowledged that a number of grant terms changed when the grant programs changed from the Safety Partnership to the STEP, but they are basically using the funds for the same activities (minus the payment for some of the safety director's benefits and a car, both of which were previously partially funded).

Outcomes from the implementation of the safety director position and his related activities (of which they are funding about 75% with the STEP grant) are significant. They have had a reduction of incident rates from 2.74 for all their association chapter members in 2004 to 1.82 in 2006. Even more impressive is a rate of 1.44 for members using safety services they offer verses 2.73 for members not using the services.[1]

The HELP grant program was designed to be monitored every six months with the success of the intervention(s) funded being determined after two years. Since the initial applications were not received until after the program began in January of 2006, WSI staff were just beginning to collect and evaluate the information to determine the success of the interventions funded and had no results yet to report. However, a review of the SurveyMonkey™ tool being used to monitor and evaluate the grant results and the fact that many of the applications reviewed indicated a lack of useful baseline data on hazards and related injuries, BDMP believes the questions asked in the survey are unlikely to collect the data needed to evaluate the outcomes of the HELP program. (See Recommendations 1.5 and 1.6)

- *Measurement of performance outcomes.* The HELP grant program has been used to fund multiple interventions that have not required the recipients to use quantifiable measures of success. For example, one of the primary objectives of the HELP grant was to decrease the frequency or severity of claims. However, 30% of the approved grant award applications reviewed included no claims or had no claims relating to the particular hazard that the intervention was designed to abate. That means there were no effective baselines from which to measure improvement and demonstrate the effectiveness of the intervention. (See Recommendations 1.5 and 1.6)

- *Effective use of research*. The HELP program has a research component that is designed to collect objective data on the benefits of specific interventions. However, in the sample of applications evaluated by BDMP, some of the same interventions were funded multiple times prior to having their effectiveness demonstrated. It would appear there is a significant opportunity to create a specific research study to measure the affect of a particular intervention by using a comparison group where the intervention had not yet been implemented. This did not appear to be considered. (See Recommendations 1.5 and 1.6)

- *Feedback from grant applicants*. A survey of denied grant recipients revealed that many of these companies re-submitted their applications with additional information and were subsequently awarded grants. Based on survey responses, WSI responds to applicants' questions in a timely manner; however, WSI should work to provide clearer explanations as to why grant requests are denied. In addition, steps should be taken to

[1] Incident rates are stated per 100 fulltime workers and are contained in a presentation made by the North Dakota Associated General Contractors in August of 2007.

make the evaluation process and criteria more visible and more easily understood by the public. (See Recommendation 1.2)

- *Increase in incident rate*. WSI's incident rate (defined as claims per 100 covered workers) did not decrease 10% in comparison to the previous biennium, it actually increased from 6.39 to 6.53, According to WSI's reported statistics, the incident rate was 6.39 in fiscal year 2005, 6.78 in fiscal year 2006 and 6.53 in fiscal year 2007.[2]

Taken as a whole, BDMP's evaluation indicates that there is room for improvement in the effectiveness of the safety grant awards program.

Objective 4: Comparison of Safety Programs to Monopolistic State Funds and Other Insurers

BDMP compared the WSI safety grant programs to those in other jurisdictions, including the states of Massachusetts, Michigan, Minnesota, Ohio, Washington and Wisconsin. Additionally, grant programs administered by the National Institute for Occupational Safety and Health (NIOSH), British Columbia, and Liberty Mutual were researched, and statistics were obtained from the Bureau of Labor Statistics on non-fatal injury and incident rates for benchmarking comparisons. Results of this review provide a number of potential suggestions for improvement in WSI's safety grant programs.

Massachusetts, Michigan, Washington, Wisconsin and NIOSH offer safety grants specifically to fund safety training and education. Safety grants to fund specific safety equipment to reduce hazards exist in Minnesota, Ohio, and Washington. British Columbia and other Canadian monopolistic funds support research of occupational safety and health prevention.

Benchmarking incident rates must be done with caution. Incident rates can be difficult to compare meaningfully across jurisdictions and even within a jurisdiction over time. Interstate comparisons can be affected by industry mix, differing policies on what is reportable in different jurisdictions, and actual public policies on safety and prevention incentives and administration. Given that caveat, Table 1-1 provides a comparison of WSI incident rates to the national and selected state incident rates:

[2] The incident rate is not a clear measure of the safety grant program's effectiveness since many other programs can affect the incident rate (both positively and negatively), including a program WSI implemented to create incentives for employers to report injuries more timely and two other programs that reward employers through reduced premiums for reductions in the frequency and severity of injuries. The incident rate is a logical comparison for overall benchmarking purposes, but would not in itself indicate the effectiveness of the safety grant program.

Table 1-1: Comparative Occupational Injury and Illness Rates 2003 - 2007

Jurisdiction	Incident Rates (not industry adjusted)				
	2003	2004	2005	2006	2007
National (BLS)[3]	5.0	4.8	4.6	4.4	Not yet available
WSI[4]	6.2	6.3	6.4	6.8	6.5
Minnesota[5]	5.5	5.3	5.1	5.1	Not yet available
Oregon[6]	5.6	5.8	5.4	5.3	Not yet available
Washington[7]	6.9	7.0	6.4	6.5	Not yet available
Wyoming[8]	5.8	5.2	5.8	Not Available	Not yet available

Of greater usefulness is a comparison of actual safety grant programs to determine the scope and criteria used by other jurisdictions, which may provide a model to increase the effectiveness of the safety grant programs in North Dakota. When reviewing the programs in the states mentioned above, comparable statistics are not available on the performance of these programs, but a review of their structure and processes do provide some guidance that may specifically address some of the weaknesses in the North Dakota safety grant programs, such as:

1. Most of the safety grants programs by these entities are much smaller in scope than WSI's. For example:

    - British Columbia made $3 million available in 2008;
    - Massachusetts makes $800,000 available each year for safety grants;
    - Michigan's education and training grant program awarded approximately $1 million;
    - Minnesota awarded 77 grants totaling $366,928 over a six-month period;
    - Ohio's maximum for any one intervention grant is $40,000 and requires the employer to match 25% of the grant; and

[3] Nonfatal injury and illness incident rates by case type, 2003 -2006 can be found at www.bls.gov/iif.
[4] See WSI Biennial Reports at www.workforcesafety.com.
[5] Nonfatal injury and illness incident rates by case type, 2003 -2006 found at www.bls.gov/iif.
[6] Oregon Annual Performance Progress Report, FY 2006-07.
[7] Nonfatal injury and illness incident rates by case type, 2003 -2006 found at www.bls.gov/iif.
[8] Nonfatal injury and illness incident rates by case type, 2003 -2006 found at www.bls.gov/iif.

- Wisconsin makes $325,000 total available for grants to alleviate injuries of health care workers and requires a 100% funding match.

This compares with WSI's $35 million total available and $50,000 maximum lifetime amount to one policyholder for the HELP grant with a 5 to 1 funding match by WSI; and $150,000 per year available under the STEP 2 grant program. There is a tiered approach based on premium.

2. Most of the safety grant programs reviewed had specific directions and/or examples for measuring outcomes. For example:

    - Massachusetts provides an example of an acceptable completed grant application and suggests a one sentence project objective;

    - Michigan ties their safety training grants specifically to activities in their strategic plan (e.g., ergonomics training and back safety, construction safety, road builders safety, hearing conservation, hazard recognition and prevention, and training for healthcare and service agencies);

    - Minnesota requires an on-site survey by a State OSHA safety/health investigator prior to awarding a grant, and requires employers with more than 10 employees to provide a baseline of OSHA recordable injuries to evaluate the success of the program or intervention;

    - Ohio also requires a signed statement by a State safety consultant verifying the need for the intervention before the application will be eligible for review;

    - Washington requires each grant agreement to specify the products or outcomes of the funded project and provides definitions of activities, outputs, and outcomes; and

    - Wisconsin lists a number of measures that will be required to be reported at the end of the grant period.

3. Some of the grant programs require an external group to provide input into the grant review and/or approval process. For example:

    - British Columbia uses a multi-stage approval process, which includes an external advisory committee in addition to an internal review and a review by peer experts;

    - Washington uses an advisory committee made up of three employee representatives, three employer representatives, two members with expertise in

safety and health selected by the Department of Occupational Safety and Health (DOSH), and one nonvoting member from DOSH who serves as committee chair; and

- NIOSH uses peer review groups from outside of their organization.

4. All of the information obtained from other jurisdictions was publicly available on their websites, which demonstrates they are opening their programs to all interested participants and are making it as easy as possible for the public to find information about their grant programs.

Conclusions

WSI needs to work to overcome current problems with the perception of credibility and sense of fairness in the safety grant programs, as well as reduce the possibility or appearance of abuse of power or favoritism. This can be done in a number of ways, including:

- *Creating a safety grant advisory committee* made up of both employers and workers. This committee could discuss the needs of the community related to safety awareness and reducing occupational accidents and illnesses; could provide advice on the redesign of the HELP program; and could review and make recommendations on grant applications; (See Recommendation 1.1)

- *Utilizing the public rulemaking process* to engage the employer and employee constituencies in the development of the eligibility requirements, the application process, and the decision making process for the HELP and STEP programs. By adding more details in the administrative rules, it automatically becomes more difficult for management to change any of the eligibility rules without first going through the public rulemaking process. (See Recommendation 1.2)

- *Marketing the STEP grant program* more actively by providing additional information on the WSI website and, at minimum, to all professional associations in higher risk classifications. With only a few grants being applied for in this program and very little information available compared to HELP, STEP appears less accessible. (See Recommendation 1.3)

- *Making better use of structured evaluation tools*. The safety evaluation process could benefit from the use of excel spreadsheets by evaluators that have pre-coded formulas for calculations that could be easily summarized and from more extensive and consistent use of a final checklist of criteria to ensure all the criteria have been met. (See Recommendation 1.4)

WSI used approximately 11% of the grant funds available in December of 2007. The low utilization of available funds in the safety grant programs is a result of the fact that North Dakota makes considerably more funds available than do most other jurisdictions; WSI curtailed the continuation of the HELP grant program in October of 2007; and only a few STEP grant programs have been awarded. Opportunities exist to expand and better market the STEP programs and to improve the HELP program achieve its stated intent. If other associations can accomplish a reduction in incident rates like those of the STEP 2 recipient visited by BDMP, the program will be well served and injurious incidents will be avoided. Certainly, more can be done to ensure safety training and information is provided to a greater share of North Dakota's workforce.

Process inconsistencies exist in the grant awards program including a lack of verification of changes of review board ratings and in ensuring a safety professional verifies with an on-sight visit that the WSI funded interventions were actually purchased and are in use by the policyholder. A detailed checklist placed in each grant file would document whether or not all the required criteria are present in the file or elsewhere in the organization and ensure all member listings and other required items have been received prior to the review board meetings. Although two separate grant check lists were used by the different grant coordinators, they did not include all the required grant criteria to be met. Lastly, although not required by statute or rule, requiring the review board members to give specific reasons why a grant application is or is not being funded would be helpful in ensuring consistency, increase credibility and increase customer satisfaction. (See Recommendations 1.2, 1.3, 1.4 and 1.7)

The research portion of the HELP program could be better designed and the grant agreement process could include specific measurable objectives to determine the success of the specific intervention being funded. This could be included in the grant agreement that both WSI and the grantee sign. This could be a simple one sentence objective with an agreed upon means for measuring the outcome, in order to ensure the grant money would help reduce hazards, near misses, injuries or illnesses. This may mean that an employer not keeping track of their hazards or near misses may not be eligible for grant money, or may receive a lesser award match. Also, WSI could take advantage of the opportunity to create specific research studies to measure the effect of a particular intervention by using a comparison group where the intervention had not yet been implemented. (See Recommendation 1.5)

WSI needs additional subject matter expertise involved in the safety grant award process and the design, measurement and evaluation of outcomes. Specifically, someone trained in research methods and analysis should be involved in designing the measurement of outcomes for the interventions being funded. In reviewing the HELP grant applications and the SurveyMonkey™ tool being used to collect data for grant evaluation success, it appears the outcome measurement design is unlikely to prove the

success of the interventions funded on a comprehensive basis. Not only did many of the employers provided grant funds not have good baseline statistics on the number of hazards, near misses, or incidents caused by the hazard for which the intervention was being implemented, but in many cases, the injuries used as documentation were not caused by the hazards the interventions were designed to abate. This leads to a questionable relationship between any results and the applicability of the intervention. The research component of the HELP grant needs to be more appropriately designed for each intervention. (See Recommendation 1.6)

Recommendations

Recommendation 1.1 Create an Advisory Committee made up of both the employers and workers the grant program is designed to serve. (Medium)

WSI Response: PARTIALLY CONCUR
WSI recognizes the importance of soliciting input from both employers and employees in the design and implementation of safety programs. However, it is WSI's position that this process would be better served by conducting focus sessions attended by representatives from a variety of industries and employee association groups. By doing so, WSI could be assured that a greater number of industries and employee groups are represented in the development and implementation of grant programs. Focus group participation will be documented to ensure that various groups, both employer and employee, are represented.

Recommendation 1.2: Utilize the public rulemaking process to engage the employer and employee constituencies in the development of HELP and STEP grant eligibility requirements, the application process, and the decision making process. (High)

By adding more details in the administrative rules, it automatically becomes more difficult for management to change any of the eligibility rules without first giving public notice.

WSI Response: CONCUR
WSI agrees that where appropriate, components of grant eligibility requirements and application process should be contained within the administrative rules, providing constituencies the ability to participate in the rule making process.

Recommendation 1.3: Market the STEP grant program more actively. (High)

This may be done by providing additional information on the WSI website and visiting and making presentations to employer and employee professional associations in higher risk classifications.

WSI Response: CONCUR

The Loss Control, Public Relations and Information Services Departments are in the process of developing a marketing plan to further promote the STEP grant program. To date, web site enhancements have been implemented which provide ready access to STEP Grant information and applications. Further marketing efforts will include making presentations to qualifying associations and the printing of STEP Grant promotional information which will be provided to North Dakota based associations.

Recommendation 1.4: Improve the consistency and credibility of the grant approval process. (Low)

This may be done by utilizing more electronic spreadsheets to score and tally ratings; by giving some explanation of the approval or denial of safety grants; and by consistently using a checklist that contains all the criteria for approval.

WSI Response: CONCUR

As recommended, electronic spreadsheets will be designed to score and tally ratings. Members of the review committee and the Grant Coordinator Specialist will be provided spreadsheets and laptop computers for the purpose of recording and summarizing scores.

The Grant Coordinator Specialist will develop a checklist of grant criteria specific to each grant program. This checklist will be monitored throughout the application/approval process and all elements of eligibility will be required to be noted prior to approval.

Additionally, the Grant Review Committee will be required to develop and record a summarization as to why a particular grant was approved or denied. This summary will be documented and maintained as part of the grant file.

Recommendation 1.5: Determine how grant outcomes will be measured prior to the awarding of funds. (High)

WSI Response: CONCUR

As noted in the audit report, over 30% of grant applications approved incurred no claims or had no claims relating to the specific intervention which was implemented. This is consistent with WSI data which indicates that of the 19,500+ active policies, only 4,000 or 20% generate a claim during a given year. This disparity in claim activity will be addressed through the implementation of a two-tier grant program allowing WSI to apply alternative techniques by which grant outcomes are measured.

For tier 1 of the grant programs which will be applied to policyholders with less than $25,000 annual premium and a limited loss history, the frequency and severity of claims for all tier 1 participants will be measured in aggregate over a one and two year periods.

For tier 2 of the grant program which will be available to policyholders in excess of $25,000 annual premium, a documented and measurable loss history will exist by which WSI will be able to establish baseline measurements. The success of individual grant programs will be measured by reductions in frequency and severity of claims over one and two year periods. All necessary documentation for providing measurements and results will be provided through WSI's claim reporting process.

Recommendation 1.6: Employ research expertise in the design and implementation of the HELP program results research. (High)

The calculation of grant results may be subjective and difficult to determine to WSI staff not familiar with appropriate measurement methods. Therefore, WSI should utilize research experts in this area to ensure appropriate measurement of the effect of funded safety interventions.

WSI Response: CONCUR

In regards to the HELP Grant program, WSI will pursue the securing of research experts to assist in the analysis, documentation and presentation of results.

Recommendation 1.7: Improve the grant monitoring program. (High)

To improve the effectiveness and credibility of the safety grant program, WSI should have qualified loss prevention staff verify the need for the intervention prior to funding and then verify that actual purchase and use of the intervention by the policyholder. This verification should be conducted within two or three months after the issuance of grant funds.

WSI Response: CONCUR

For upper tier accounts, those accounts in excess of $25,000 annual premium, a safety assessment will be performed by a WSI Safety Consultant as part of the application process. The Safety Consultant will review the existing safety management system, make recommendations as to improvements or if not currently available, assist in the development of a safety management system.

Additionally, for all upper tier accounts, verification of the purchase and implementation of the intervention will be conducted by a Safety Consultant within a prescribed time period. The purpose of this verification will be to ensure the funding for the intervention was utilized appropriately and the intervention was properly implemented.

For lower tier accounts, those accounts less than $25,000 in annual premium, the Grant Program Specialist will be responsible for verifying the purchase and use of the intervention.

Element 2: Board of Directors Evaluation

Element Two encompasses two objectives:

1. Consider WSI Board activities and involvement during the reporting period and determine whether the Board adhered to its approved governance principles.

2. Consider the WSI Board's current governance principles and benchmark them against other monopolistic states and large insurance companies.

This section addresses each objective independently below.

Key Activities

To conduct this analysis, BDMP undertook the following activities:

- Reviewed quarterly, committee, and special Board meeting minutes taken during the evaluation period;
- Determined, after reviewing Board meeting minutes and conducting interviews, that we had sufficient evidence to support our review of adherence to Board principles without listening to recorded audio minutes of Executive Board sessions that were closed to the public;
- Reviewed North Dakota State Statute 65-02 regarding the organization and management of the Workforce Safety and Insurance Organization;
- Reviewed WSI Strategic Plans in effect during the evaluation period;
- Reviewed WSI Board bylaws and governance policies in effect during the evaluation period;
- Reviewed WSI Board bylaws and governance policies enacted in March 2008;
- Interviewed seven current and past Board members to understand history of decisions and actions taken during the evaluation period;
- Interviewed several WSI managers and staff to understand history of decisions and actions taken during the evaluation period;
- Reviewed other pertinent supporting documents, reports, and performance measures utilized by the Board during the evaluation period;

- Reviewed other consulting reports that addressed Board performance including the 2006 Performance Evaluation (Octagon Report) and the 2008 WSI Management & HR Report (Conolly Report).
- Reviewed literature from various sources on board governance trends and issues;
- Reviewed board governance documents from other monopolistic regions (including the State of Ohio and Canadian province of British Columbia); and,
- Reviewed publicly available information from private workers' compensation companies.

Board Adherence to Governance Principles

Objective

BDMP was asked in Element Two to review the WSI Board's activities during the evaluation period to determine whether they were in accordance with the governance principles in effect. BDMP also was asked to identify any specific incidences where the Board or Board Member's actions violated those principles.

Observations & Findings

BDMP's review of WSI materials noted many broad and detailed guidelines that would be difficult to evaluate in minute detail. Therefore, we pursued a method that considered Board governance from two perspectives.

1. **Strategic Plan Objectives**: As the Board is responsible for overseeing the implementation of the WSI strategic plan, we reviewed Board meeting minutes (including committee meetings) to identify examples of discussions and actions taken with respect to the objectives outlined in the Strategic Plan in effect during the evaluation period.

2. **WSI Board Governance Policy:** BDMP reviewed WSI's Governance Policies in effect during the evaluation period, identified key governance guidelines, and grouped these guidelines into high-level categories that capture the intent of policy guidelines. We then reviewed Board meeting minutes (including committee meetings) to determine whether these policies were followed.

Our review emphasized the Board's *adherence* to the above components during the time period examined for this evaluation.

Adherence to Strategic Plan Objectives

- **Develop and Expand a More Proactive Safety Program**: During the time period examined for this evaluation, BDMP noted that the WSI Safety Program, results, and budget were discussed periodically as part of the Quarterly Board meeting and Audit Committee meetings. Details were presented to Board members by the CEO or pertinent WSI managers responsible for the safety programs.

- **Streamline Reporting/Processing**: During the time period examined for this evaluation, BDMP noted the WSI Board consistently reviewed and discussed actions and investments that would support the improvement of customer interactions in the claims process. The Board regularly reviewed WSI performance metrics presented by the CEO that provided insight into key indicators such as claims processing time, complaints, legal actions, expenses, and other issues. The Board also regularly engaged in discussions related to investments in technology infrastructure, staffing levels, and management capabilities in an effort to position WSI to continue improving its operations. The Board regularly reviewed customer satisfaction results, WSI staff turnover, and other leading indicators.

- **Improve Communications with North Dakota's Workforce, Employers, Medical Community and WSI Employees**: During the time period examined for this evaluation, BDMP noted the WSI Board regularly reviewed the results of customer satisfaction surveys, WSI staff feedback, and other information regarding stakeholder satisfaction. In addition, WSI implemented recommendations to improve its website and to make it more user-friendly for workers and employers, and to make it a more efficient source of information to the public. Of note, the Board also engaged a survey firm to conduct an assessment of the WSI culture in order to better understand underlying management and staff issues during the timeframe reviewed by BDMP.

- **Achieve/Guarantee the Integrity of WSI's Data/Data Systems**: During the time period examined for this evaluation, BDMP noted the WSI Board invested considerable time discussing and evaluating the WSI Information Technology Transformation Plan (ITTP), reviewing technology security issues, considering findings from external audit reports, and otherwise taking action to support management in its efforts to protect worker and employer data.

- **Assure Fund Solvency with Integrity:** During the time period examined for this evaluation, BDMP noted the WSI Board regularly reviewed WSI fund issues including investment performance, fund level to liabilities, and the impact on fund levels caused by rate changes. The Board regularly made use of both internal and external resources to evaluate the appropriate fund levels and took steps in an to attempt to return the fund to state mandated limits through such measures as the distribution of premium rebates to employers and funding safety programs. BDMP noted that the fund surplus was regularly

identified by the board members interviewed as the most important metric currently being considered by the Board. However, BDMP also noted that while WSI made efforts to be in compliance, actual compliance was not demonstrated during the reporting period. Further evaluation of the WSI surplus is provided as part of Element 7.

- **Enhance WSI Staff Development**: During the time period examined for this evaluation, BDMP noted the WSI Board approved participation by WSI staff in national conferences and received updates from the Director on staff development activities. (See Recommendation 2.5)

Adherence to Board Governance Policy

The following considerations are a summary of the entire set of policies outlined in the Board Governance Policy in effect during the evaluation period.

- **Oversee Excellence in Products / Services**: During the time period examined for this evaluation, BDMP noted the WSI Board reviewed WSI performance at both the Audit Committee and Quarterly meetings. The primary sources of information were the Quarterly Operating reports presented by the WSI Quality Assurance Manager. The Internal Audit Manager reviewed the status of current internal/external audits. Additional performance information and commentary on performance variations was regularly provided by the CEO in his report to the Board. Additional performance information—or information related to actions and decisions that impacted performance—were regularly provided by other WSI managers. (See Recommendation 2.4)

- **Maintain strategic perspective and conduct biennial planning cycle**: During the time period examined for this evaluation, BDMP noted the WSI Board conducted retreats and training sessions with an emphasis on staying focused on strategic issues. In particular, the Board undertook to appropriately implement the Carver governance model, a respected and accepted governance methodology to help keep boards focused on the correct activities. We noted frequent discussion in Board meeting minutes of updating bylaws and governance principles to reflect WSI's strategic objectives as drafted by WSI staff and approved by the Board.

  BDMP noted that meeting minutes and CEO presentations discussed the biennial budget process and specific details related to different line items. This included a regular review of rates, the surplus, staffing levels, technology investments, and other key items of the budget. Annual retreats were conducted to discuss strategic planning issues.

- **Maintain appropriate leadership role while adhering to the governance process, developing Board capabilities, and supporting fair and open decision-making**: During the time period examined for this evaluation, BDMP noted the WSI Board emphasized an appropriate level of review of performance metrics and asked pertinent questions to

understand how WSI staff were supporting WSI's mission. BDMP found no evidence to suggest that WSI was involved in discussing specific cases or individual issues unless the impact of a particular issue had larger strategic implications. (See Recommendation 2.4)

Board meetings followed the accepted guidelines of "Robert's Rules of Order" and regular training was conducted on these rules. Meeting minutes reflect that the rules were followed with quorums regularly taken, voice given to parties in an appropriate manner, and other procedures followed appropriately.

BDMP noted that Board training and development was a regular part of each quarterly Board meeting and that several additional Board training sessions were held during the evaluation period on the Carver governance methodology. The Board also supported some participation by Board members in national conferences where they were able to see how WSI compared with other state organizations. (See Recommendation 2.1 and 2.5)

The Board utilized external sources of advice to provide guidance on contentious or confusing issues. (See Recommendation 2.1) WSI also invested in conferencing technology to make meeting participation—especially if called on short-notice—easier for Board members who lived some distance from WSI.

BDMP noted the Board has had some confusion and instability in relation to the Internal Audit function. Specifically, the Board at one point considered and approved a recommendation by the CEO at that time to change the reporting structure of the Internal Audit manager to report directly to the CEO instead of the Board Audit Committee Chair. The initial, unanimous agreement by the Board to this change was concerning in that such a change would clearly violate the important independence of the Internal Audit group from WSI senior management. While this decision was ultimately overturned, the fact that it was seriously considered by the Board in the first place suggests a lack of experience by the Board in general in the area of internal controls and audit functions. (See Recommendation 2.1)

Additionally, BDMP noted from its review of Audit Committee Meeting Minutes and interviews with Board members that the Internal Audit Manager position has experienced significant turnover, instability, and turmoil. In particular, the final months of this evaluation period experienced a public "scandal" that created significant, negative publicity and attention for WSI employees and the Board. BDMP noted that internal audit records and programs were often incomplete and poorly documented. We believe the lack of consistent leadership in the Internal Audit Manager role has made it difficult for WSI to implement consistent internal controls and audit programs that could help improve its credibility with outside parties. (See Recommendation 2.2)

While the Board has made efforts to adhere to and follow sound governance policies, the instability and turmoil surrounding the Internal Audit function and perceived lack of audit experience by Board members has been an obstacle to good governance.

- **Enforce executive limitations and review executive performance**: During the time period examined for this evaluation, BDMP noted the Board endeavored to exercise an appropriate level of executive oversight during this evaluation period. The minutes show the Board regularly focused on WSI performance measures that reflected stable or better than historical performance. The CEO regularly informed the Board of ongoing issues with WSI performance. Based on our analysis, it appears that the WSI CEO communicated openly and transparently with the Board regarding ongoing management issues.

  We noted that the Board attempted to initiate processes to solicit WSI management and staff feedback on CEO performance. Board members were asked to complete CEO evaluations and staff members were asked to provide confidential input to the evaluation process. However, the Board received only minimal feedback from these efforts.

  As explained above, BDMP believes the challenges related to the Internal Audit function have had an impact on the Board's ability to effectively enforce executive limitations and evaluate executive performance.

Conclusion

BDMP determined that the WSI Board generally adhered to the governance principles in effect during the evaluation period. We did not observe instances of deliberate WSI Board actions or involvement that went against Board governance principles in place, however, we did note the following:

- **Documentation of Board Activities and Decisions:** The WSI Board consistently documented the content of its quarterly meetings and committee meetings. We found these meeting minutes to be reasonably detailed, descriptive, and in line with what one would expect from a board that is held publicly accountable. In those instances where the Board chose to conduct executive sessions for confidential discussions on sensitive topics, the meeting minutes clearly state the guidelines for these meetings. Also, one interviewee indicated that all executive sessions included a WSI legal staff member —usually the lead counsel— present at these sessions to ensure they followed the rules and stayed on topic. Actual decisions were voted on in the open meetings.

- **Board Training:** The WSI Board held regular training on board governance practices and identified/utilized outside resources to help them improve their adherence to these policies. BDMP noted that while the Board has supposedly utilized the Policy Governance Model (aka "Carver Model") since its inception, there appears to have been periodic uncertainty or concern about whether they were correctly following this model's precepts.

BDMP noted that the Board undertook and continues to implement several measures including the retention of a board governance consultant and significant board training to improve board member understanding and performance of its governance policies. (See Recommendation 2.5)

- **Board Member Skills & Experience:** Related to the above finding, BDMP noted that WSI Board members appear to lack more specific experience in accounting, insurance, and general board member responsibilities that may cause them to be too dependent on WSI staff or outside experts to make impartial decisions in the best interest of WSI stakeholders. In our research and experience, we have found that board members' background, knowledge, and abilities are often more critical to successful board performance than adherence to any particular governance model or policies.

  Board training sessions will not substitute for the inclusion of relevant pre-existing professional skills or experience on the board.

  An example that demonstrates this issue relates to the previously described decision by both the Audit Committee and full Board to approve a change that would have had the Internal Audit Manager report directly to the WSI CEO in most organizations. The Internal Audit Manager reports directly to the Chair of the Chairman of the Board's Audit Committee with a "dotted-line" administrative connection to the CEO. Such a change would have compromised the independence of this position.

  To their credit, the Board reversed this decision as soon as they received feedback that pointed out the problems with this change. However, the fact that this change was proposed, reached a vote, and was then approved unanimously by Board members with little debate or concern noted in meeting minutes suggests to us a lack of experience with such issues.

  BDMP also noted that both the State of Ohio and Canadian province of British Columbia have mandated that specific skills be represented on their boards and that members with these skills lead certain committees. (For example, both stipulate that a CPA must head the Board Audit Committee.) (See Recommendation 2.1)

- **WSI Calculation of Premium Paid Calculations for Board Members:** BDMP noted that the current process for determining board member qualification with respect to the premium paid calculations is open to interpretation. Specifically, BDMP noted an instance where board member qualification was subject to whether a premium rebate was applied to a total premium amount which impacted the qualification in the individual being representative of employers from a lower-tiered premium category on the WSI board. (See Recommendation 2.3)

- **Internal Audit Department Issues:** The turmoil and lack of leadership in WSI's Internal Audit function became a distraction to the Board being able to confidently fulfill its responsibilities to WSI stakeholders. Given the lack of professional audit experience and skills on the WSI Board, it is critical that the WSI Board work toward resolving this issue. (See Recommendation 2.2)

- **Performance Metrics:** The WSI Board currently uses a quarterly report that includes over 100 performance metrics which is too many for any group to discuss and consider during the course of a one-day board meeting. A more effective approach would be to carefully select a small number of critical, strategic metrics that inform the Board on issues deemed critical to WSI. (See Recommendation 2.4) In our experience with boards varies balanced scorecard systems, we have found 15-25 metrics to be a manageable number.

Benchmark Governance Principles against Other Organizations

Objective

BDMP was asked to benchmark WSI's Board governance principles against other monopolistic states and large insurance organizations. In this objective, we sought to understand how WSI's Board governance principles compared with similar organizations.

Observations & Findings

Overview of Board Governance Models

Boards typically exhibit a style that is unique to each organization and evolves over time based on both internal and external events. For instance, a newly formed organization may have board members that include the founder group who are also managing day-to-day operations. Over time, as the organization matures and becomes stable, it may hire a professional management team and give the board more time to focus less on day-to-day issues and more on long-term strategic issues.

Despite the differences and many variations, Boards typically adhere to one of five categories for board governance as described below.

- **Advisory Board:** Primarily a small group of individuals with unique skills or connections who advise the leader or founder of an organization in areas outside his/her personal experience. Advisory Boards typically emphasize their relationship with the CEO who is usually also a board member – if not the Chairman of the Board.

- **Patron Board:** This board model is often found in large, non-profit organizations that have fund raising as a main objective of the Board. In this instance, an organization may have a large number of board members whose primary responsibility is helping to raise money.

More rigorous board responsibilities (such as internal audit or strategic planning) may be addressed via a subset of the larger board in the form of an executive committee.

- **Co-operative Board:** This model covers organizations who wish to follow a collaborative decision making style with no specific leadership identified. In this instance, board members often consist of a mix of managers and outsiders who work together to reach consensus on decision and then implementing the decisions.

- **Management Board:** Some boards are designed to augment the capabilities of the organization's management team with board committees paralleling internal functions such as marketing, operations, and finance. This arrangement may exist for organizations building staff capacity or seeking to avoid high administrative costs by leveraging board member skills.

- **Policy Setting Board:** The Policy Setting governance model (as exemplified by the Carver Model) assumes the existence of a professional management team that is responsible for implementing policies set by the board. In this model, the board emphasizes an "outward" focus through the setting of the organization's vision and strategy. They then follow-up on these policies by reviewing performance against pre-defined metrics and standards.

  The implementation of the vision and strategy is delegated to the management team who is responsible to the board for achieving acceptable performance for stakeholders within the framework set by the board. In most instances, the delegation of implementation to the management team is done through a professional director or CEO who then oversees the management team.

Analysis of Other Workers' Compensation Programs

BDMP considered four other states (Ohio, West Virginia, Wyoming, and Washington) and British Columbia that have utilized the monopolistic workers' compensation model. Of these, one (West Virginia) has abandoned the monopolistic model and moved to a competitive model; two (Washington and Wyoming) operate workers' compensation systems under their respective labor departments; and two (Ohio and British Columbia) utilize a separate governing board with the CEO accountable to the board for fulfilling the mission of the organization. BDMP also reviewed publicly available information for private workers' compensation companies. The following points outline our findings.

- West Virginia is in the process of moving from the monopolistic model to the private, competitive model with the final transition occurring this summer.

- Washington's workers' compensation function is handled within the Department of Labor and Industries under the executive branch. Washington has a *Workers' Compensation Advisory Committee* that is a non-governing board with representatives from business,

organized labor, self-insured employers, and the board of Industrial Insurance Appeals. The committee provides advice and serves as a sounding board to the Washington Director of Labor & Industries and the Assistant Director for Insurance Services on matters pertaining to the state's workers' compensation system.

- Wyoming's workers' compensation program is a division within the Department of Employment overseen by the executive branch.

- Ohio's Bureau of Workers' Compensation has recently completed a comprehensive overhaul driven by governance scandals in 2006–2007. The Ohio Legislature enacted new rules and regulations that maintained a separate workers' compensation system with the CEO/Director accountable to an independent board representing diverse stakeholders. The Ohio statutes and board governance documents strictly adhere to the Policy Governance Model with the board focused on setting policy and measuring results and the CEO accountable to the board and focused on policy execution.

- British Columbia's workers' compensation system has a reputation within the workers' compensation community for good performance and governance. BC utilizes a monopolistic model with an independent workers' compensation program led by a "President" (CEO / Director) who is accountable to an independent board of directors. BC utilizes the Policy Governance Model with the board focused on setting policy and measuring results and the President accountable to the board and focused on policy execution.

- BDMP reviewed publicly available information from several private workers' compensation companies and determined that most are adhering to different levels of the Sarbanes-Oxley (SOX) guidelines emphasizing internal controls, and a robust internal audit function. Most private workers compensation organizations are required to provide annual reports to the legislatures in those states they serve. Board governance models vary from an advisory board with a strong CEO also serving as board chairman to a policy board with the CEO accountable to the board.

Analysis of Industry Best Practices

BDMP considered sources of information from both academia and the professional community[9] with respect to overall governance trends across multiple industries. BDMP made the following

[9] Sources included:

- Foundation Governance: The CEO Viewpoint, The Center for Effective Philanthropy, 2004.
- Beyond Compliance: The Trustee Viewpoint on Effective Foundation Governance, The Center for Effective Philanthropy, 2005.
- "New Work for the Nonprofit Board," Harvard Business Review, September 1996.
- "Charting the Territory of Nonprofit Boards," Harvard Business Review, January 1989.
- "Empowering the Board," Harvard Business Review, January 1995.
- "The Dynamic Nonprofit Board," McKinsey Quarterly, May 2004.

observations from this research and used this background data as part of its evaluation of the Board's performance:

- Sarbanes-Oxley (SOX) has had a significant impact on board focus, causing boards to expend considerable time and resources on monitoring internal controls and processes. Many experts believe this is a knee-jerk reaction to the scandals in 2001 and 2002 with companies such as Enron, WorldCom, and Tyco. Some surveys suggest companies have been forced to spend an average of $5.0 million in SOX compliance related activities.

- The increased emphasis created by SOX on internal controls has had the additional impact of re-igniting the debate around board governance and the board's role in organizations. In general, our research indicated a continued belief that organizations are best served by boards that are focused on the long-term strategy of the organization—not day-to-day management. BDMP believes that the current emphasis on internal audit capabilities will eventually stabilize and boards will return to a more future-focused orientation, albeit with improved internal audit processes. This can already be seen in national efforts to modify SOX and reduce some of its more burdensome requirements.

- The increased demands being placed on boards have led to larger time and resource commitments by individual board members. Many organizations have tried to adjust to this situation by employing different strategies for accomplishing the board's work, such as conducting more board committee meetings and fewer full board meetings and using technology to support remote participation in meetings. Nevertheless, some experts believe boards are being asked to do too much with limited resources and time.

- A survey conducted in 2005 noted that directors from Fortune 200 companies[10] believe that effective corporate governance had less to do with traditional board governance policies and more to do with the specific background, knowledge, and abilities of directors on the board.

In general, we found that experts continue to emphasize that the board's primary role should be setting the long-range vision and policies for an organization, challenging management on their planning assumptions, and being on the lookout for unanticipated obstacles and dangers.

Conclusion

The *Policy Setting Governance Board Model* (aka the "Carver Model") is a reasonable model to best represent the interests of the various WSI stakeholders and North Dakota's citizens. This model assumes the existence of a professional management team that is responsible for implementing policies set by the board. The Board is "outward" focused on the organization's vision and strategy and measures performance against pre-defined metrics and standards.

[10] "Leading from the Boardroom," Harvard Business Review, April 2008.

The implementation of the vision and strategy is delegated to the management team accountable to the Board for achieving acceptable performance for stakeholders within the framework set by the Board. Delegation to the management team is done through a professional director or CEO who oversees the management team.

BDMP's conclusion is based on the following findings:

- **Professional Management Team:** WSI is a mature organization with a professional management team, supporting staff, operating procedures, and proven experience in achieving its mission. The presence of a management team capable of implementing the policies set by the Board reduces the need for the Board to actively participate in the details of day-to-day operations. WSI management and staff have demonstrated their ability to perform the required tasks of delivering workers' compensation insurance without having the Board directly involved in day-to-day management issues.

- **Role of Board in Challenging Management Assumptions:** Our research of other organizations supports the Board's primary role as an outward-focused, policy-setting body of an organization. A board is seen as the one body of an organization whose detachment from day-to-day operations is crucial to their function of challenging management about their assumptions and decisions.

- **Benchmark with other workers' compensation organizations:** The board governance documents adopted by WSI are similar in style and content to those reviewed for Ohio and British Columbia—two organizations that follow the same governance model. In particular, WSI's use of the Internal Audit Committee for oversight of WSI operations and controls is consistent with industry practices. However, this committee can only be effective with a competent Internal Audit Manager. BDMP noted that there has been high turnover and instability in this position which impacts the Internal Audit Committee's ability to fulfill its role.

While we believe the Policy Setting Governance Model is appropriate and reasonable for WSI, it is only one part of good governance. The governance model is just that – a model. It serves as a framework or structure by which an organization can maximize the value of board members time and the organization's management to benefit stakeholders. As we have discussed previously, we believe WSI must also consider the professional skills and experience board members bring with them to WSI board membership. (See Recommendation 2.1)

Recommendations

The following recommendations are the result of our combined observations, interviews, research, and experience in similar engagements.

Recommendation 2.1: Consider modifying Board member appointment criteria to include specific skills and experience relevant to a state workers' compensation fund. (High)

The Legislature and Governor should identify specific knowledge and/or professional skills (e.g. CPA, actuarial, legal, etc.) for representation on the WSI Board.

WSI Response: CONCUR

This recommendation is similar to a recommendation obtained in a prior review. Although no formal Board position exists, the Board has had discussions at multiple meetings relevant to requiring specialized expertise for Board members. The gist of the discussions has been that specialized skills are not necessary. Other criteria such as interest, willingness to serve, and commitment to attend meetings are as important as specific skills. To the extent that specialized expertise is needed as part of the Board's decision-making responsibilities (i.e. actuarial, legal, accounting, IT, etc.) these resources are currently accessible or otherwise could be obtained. The WSI Board concurs and will consider this recommendation at a future Board meeting and determine whether they want to pursue changes legislatively.

BDMP Concluding Remarks

We acknowledge that WSI can obtain expertise in additional subject matter areas to advise the board. However, we believe it would be beneficial and important to have individuals on the board with relevant expertise and experience in the critical issues on which the board has to make decisions. This strengthens the board's capacity to actively engage and participate in understanding, discussion, and decision making on issues critical to WSI and its mission.

Recommendation 2.2: Fill the Internal Audit Manager position and give this person appropriate Board member support and resources to perform the function. (High)

The WSI Board should give special attention to attracting and retaining the best possible person for the Internal Audit Manager position—especially given WSI's status as a state agency that must account for its activities to a large and diverse stakeholder group. The Internal Audit Manager should report to the chair of the audit committee, be allowed at least one regularly scheduled executive session with the Board without WSI management present per year, and participate in regularly scheduled Board audit committee meetings.

WSI Response: CONCUR

As of September 8, 2008, the Internal Audit Manager position has been filled. The Internal Audit Manager will continue to report functionally to the Board Audit Committee and administratively to the CEO. The Internal Audit Manager is also expected to participate in the regularly scheduled Audit Committee meetings. Executive sessions will be permitted to the extent the law allows.

Recommendation 2.3: Clarify the process and responsibility for calculating the premium rates used to determine board member eligibility. WSI should seek a formal opinion from the Office of the Attorney General with respect to this issue. (Medium)

WSI Response: CONCUR
WSI has documented the process that will be used for determining the premium levels of future Board applicants and has notified the Governor's office on how the premium calculations will be determined. WSI will bring the issue of the request for an attorney general's opinion to the Board for consideration.

Recommendation 2.4: Better focus the performance measurements reviewed by the Board and reduce the quantity of metrics to a more effective number. (Medium)

WSI Response: CONCUR
Currently, WSI Management is in the process of developing a more refined set of key performance indicators that will provide a quick glance of WSI operations. These will be reviewed weekly and monthly by the Executive Team.

Under Policy Governance®, primary reporting to the Board will be through the CEO monitoring reports for the Board Executive Limitations and Ends policies, as well as reporting on the progress of the strategic plan.

Recommendation 2.5: Develop and maintain a formal Board handbook that captures key information required for Board membership and involvement in one easy-to-use reference. (Low)

> BDMP noted that other organizations have developed formal board handbooks that collect all critical board documents in one location including governance policies, state statutes, meeting formats and rules, industry overview, definitions of key terms, explanation of key performance metrics, and other information deemed critical for informed participation in the governance process. BDMP noted that the workers' compensation organization for British Columbia has created a board handbook that was particularly well designed and useful.[11]

WSI Response: CONCUR
On August 28, 2008, the Board implemented a new software as a service (SAAS), OurBoardroom Technologies: www.ourboardroom.com. This platform currently contains the governance policies, meeting agendas, meeting minutes, CEO monitoring reports and bylaws. The future plans for this site are to include all other information that is deemed critical for the board to be informed and make decisions. This electronic format for Board information is

[11] www.worksafebc.com/about_us/assets/PDF/BOD_Manual_2005.pdf

preferable to a paper-based handbook since it is easier to update and accessible anywhere, anytime.

Element 3: Performance Measures

Objective

Evaluate the performance measures maintained by the organization as required by NDCC Section 65-02-30. This evaluation should include:

1. An appraisal of the accuracy of the information gathered by WSI and used to measure its performance.

2. An evaluation of the methods and processes used to gather the data related to the measures, to ensure that the data is accurate and is inclusive enough to fairly represent the purpose of the measure.

3. An analysis to determine whether each measure represents a valid basis on which to judge the organization's performance.

4. A comparison of the results of specific performance measures (as many as are comparable) with other monopolistic states and large, industry-leading insurance companies specializing in providing workers' compensation insurance. WSI's results should be benchmarked against those other entities.

Key Activities

To complete these evaluations, BDMP undertook the following activities:

- Conducted interviews with a variety of WSI staff. The Quality Assurance Director and the Chief of Injury Services supplied the majority of the information regarding organizational performance measures. BDMP also discussed specific departmental and individual performance metrics with:

    - Chief Governance Officer
    - Medical Services Director
    - Claims Director
    - Medical Director
    - Provider Relations Manager
    - Claim Supervisors (2)
    - Claim Adjusters (6)
    - Case Managers (2)

- Utilization Review Supervisor
- Return to Work Supervisor
- PPI Auditor

- Conducted an analysis of the accuracy of a subset of the measures contained in the current WSI Operating Report. By first validating the specific data elements in the custom data files supplied by WSI in support of the random selection of claims for review purposes, BDMP was then able to assess the accuracy of several key measures from the Operating Report by independently replicating the calculations used.

- Conducted interviews and/or reviews of published performance reports with comparable external organizations including:

  - Washington Department of Labor &Industry
  - Ohio Bureau of Workers' Compensation
  - Montana State Fund
  - Minnesota Department of Labor & Industry
  - British Columbia Workers' Compensation Board
  - Association of Workers' Compensation Boards of Canada
  - Oregon Department of Consumer and Business Services
  - Louisiana Workers' Compensation Corporation
  - IAIABC Information Resources & Performance Measures Committee

- Reviewed recent relevant WSI consultant reports, such as the Ward and Connelly studies, that contained evaluations of WSI performance and/or benchmarks to other workers' compensation payers and systems.

- Obtained documentation from the SIU Manager in order to validate a subset of performance metrics reported under Legal/SIU on the Operating Report.

Observations & Findings

Accuracy of Claim Metrics

Before attempting to assess the accuracy of the claim metrics included in the WSI Operating Report, BDMP first attempted to validate the accuracy of the claim data received in support of the individual claim evaluations. WSI technical staff provided BDMP with a data extract file listing all new claims from July 1, 2002 through December 31, 2007 along with Microsoft Excel files used to track claim acceptance rates (CL0961 Acceptance Rates FYXX.xls). BDMP validated

the information contained in these data files by logging in to the WSI claim system and confirming the accuracy of key data fields against the information in the claim system for a total of 250 claims.

Once the accuracy of the information contained in these data files was established, that data was used to independently verify several of the most critical claim metrics included in the Operating Report. Since the custom data extracts contained only basic demographic and cost information for each claim, BDMP was not able to independently validate all of the detailed metrics currently included in the WSI Operating Report. The findings for those claim metrics that could be validated suggest that WSI Operating Reports reflect data that are accurate.

The first measure BDMP was able to confirm was the total new claims reported by fiscal year. As illustrated below, the totals from the Operating Report matched the totals in the custom data extracts with a variance of less than 0.1%.

Table 3-1: WSI New Claims Filed by Fiscal Year

Year	Operating Report 12/31/2007	BDMP Data Files	% Variance
Fiscal Year 2005	19,887	19,864	-0.1%
Fiscal Year 2006	21,588	21,586	0.0%
Fiscal Year 2007	21,309	21,291	-0.1%

The discrepancies in the number of claims filed by fiscal year may have been caused by a different query logic used to select claims for the BDMP data. Also, it is possible that the specific status of some claims may have changed during the period between the original query for the 12/31/07 Operating report and the 4/20/08 BDMP data request. (E.g. Changes such as late reported or withdrawn claims that may have occurred in the underlying data between the two queries.)

Similarly, when BDMP compared the percent of all claims reported within a certain number of days from the date of injury (i.e. lag time), the variance between the Operating Report and the custom data extracts was less than 1% for fiscal years 2006-2007.

Table 3-2: Lag Time to Report Injuries by Fiscal Year

	Operating Report 12/31/2007	BDMP Data Files	% Variance
Fiscal Year 2005			
< 1 day	10%	15.0%	50.0%
< 7 days	58%	59.1%	1.8%
< 14 days	75%	75.5%	0.5%
< 21 days	84%	82.0%	-2.5%
< 31 days	89%	86.5%	-2.9%
Fiscal Year 2006			
< 1 day	40%	39.7%	-0.9%
< 7 days	73%	73.6%	0.7%
< 14 days	83%	83.7%	0.7%
< 21 days	88%	87.7%	-0.5%
< 31 days	91%	90.7%	-0.4%
Fiscal Year 2007			
< 1 day	45%	45.1%	0.1%
< 7 days	77%	76.4%	-0.9%
< 14 days	85%	85.0%	-0.1%
< 21 days	89%	88.6%	-0.6%
< 31 days	92%	91.6%	-0.6%

As illustrated in Table 3-2, fiscal year 2005 did yield a larger variance for the number of claims reported within one day, however it appears that this was most likely due to a calculation error on the Operating Report rather than a data accuracy issue. According to the Operating Report, 10% of the 19,887 new claims in fiscal year 2005 were reported within 1 day, for a total of approximately 1,989 claims. According to the data files submitted to BDMP, there were a total of 2,962 claims reported within 1 day of the date of injury. The 2,962 total included 1,003 claims that were reported on the same day as the date of injury (0 days lag) and 1,959 claims that were reported the day following the date of injury (1 day lag). Follow up conversations with WSI staff supported the theory that the 2005 Operating Report may have incorrectly only included those claims with 1 day of reporting lag and did not count the 0-day lag claims. If just the 1-day lag claims are counted from the BDMP data file, the variance to the Operating Report for claims reported within 1-day drops from 49.8% to (1.5%).

The initial claim acceptance rates also were within 1% of each other once the BDMP data file totals were adjusted to exclude the denial reasons currently excluded from the Operating Report calculation, i.e. no signed injured worker report or no medical treatment.

Table 3-3: Initial Claim Acceptance Rate by Fiscal Year[12]

	Operating Report 12/31/2007	BDMP Data Files	% Variance
Fiscal Year 2005	94%	93.1%	-1.0%
Fiscal Year 2006	92%	91.5%	-0.5%
Fiscal Year 2007	92%	91.4%	-0.7%

One area where there was a slightly greater discrepancy (although still less than 5% variance) between the Operating Report results and those taken from the custom data extracts was in the number of new claims per year per adjuster. The calculation used in the Operating Report is described as the "number of new claims filed, divided by the number of claims adjusters."

"Claims adjuster name" was an available field in the data extracts provided to BDMP. As a result, evaluators were able to total the number of new claims for each fiscal year by individual adjuster name. Denied claims were then added to the individual adjuster totals and the results were averaged, to arrive at the number of new claim assignments per adjuster per fiscal year.

Table 3-4: Average New Claims per Adjuster by Fiscal Year

	Operating Report 12/31/2007	BDMP Data Files	% Variance
Fiscal Year 2005	496	478	-3.7%
Fiscal Year 2006	554	560	1.1%
Fiscal Year 2007	552	559	2.4%

The slightly higher discrepancies between the Operating Report and the BDMP data file was determined to most likely be due to the issue of when the data was pulled. The adjuster name in the BDMP data file represents the name of the adjuster currently assigned to the claim as of the date the data was pulled (April of 2008) rather than the adjuster that was assigned during the original claim registration process. Adjusters who have left WSI since fiscal year 2005 may not be included in the BDMP data files as any of their open claims would have been transferred to an active adjuster upon their departure. Given the potential differences in the underlying data caused by adjuster attrition, the variances of this metric were not deemed significant.

Finally, since the Operating Reports also contain a large number of financial metrics, BDMP compared financial information to the data contained in the independently audited financial

[12] Initial Claim Acceptance rates are based on the first claim compensability decision made by the adjuster. These results may differ from the ultimate claim acceptance percentage as additional research conducted by the adjuster may ultimately uncover information that would lead them to deny a claim they had initially chosen to accept. Conversely, claims that were initially denied by the adjuster may ultimately be accepted once additional information has been supplied and/or once a denied claim has moved through the North Dakota dispute resolution process described in Element 9.

statements. BDMP found no discrepancies between the financial metrics included in the Operating Reports and the results reported in the respective audited financial statements.

Overall, the claims measures that BDMP was able to independently derive from the data files supplied tracked extremely closely with the data in the Operating Reports. The differences that we did uncover were all less than the 5% variance threshold that was deemed significant. Any differences could be attributed to slight variations in the logic used to extract the custom BDMP data files and/or to the timing of the data extractions.

BDMP did not make any recommendations related to the accuracy of the claim information contained on the WSI Operating Reports.

Accuracy of Legal/SIU Metrics

BDMP selected a subset of Legal/SIU metrics to validate through reconciliations with information maintained by the SIU department. The Legal/SIU metrics selected for testing were Total Restitution and Total Savings for the Quarterly WSI Operating Reports during calendar years 2006 and 2007. We observed unreconciled differences in information reported with respect to Legal/SIU data during the period of our review. This can be seen in tables 3-5 and 3-6.

The reconciliation of the information reported in the WSI Operating Reports is as follows:

Table 3-5: Reconciliation of Total Restitution reported in the WSI Operating Reports during calendar years 2006 and 2007

	Operating Report	Data from Management	Difference
Fiscal Year Ended June 30, 2006:			
Quarter ended March 31, 2006	$ 100,136	$ 98,438	$ 1,698
Quarter ended June 30, 2006	61,614	34,166	27,448
	$ 161,750	$ 132,604	$ 29,146
Fiscal Year Ended June 30, 2007:			
Quarter ended September 30, 2006	$ 49,760	$ 31,817	$ 17,943
Quarter ended December 31, 2006	18,734	22,924	(4,190)
Quarter ended March 31, 2007	61,878	75,531	(13,653)
Quarter ended June 30, 2007	6,836	6,896	(60)
Fiscal Year Ended June 30, 2007	$ 137,208	$ 137,168	$ 40
Fiscal Year Ended June 30, 2008:			
Quarter ended September 30, 2007	$ 15,088	$ 15,088	$ -
Quarter ended December 31, 2007	13,027	13,028	(1)
	$ 28,115	$ 28,116	$ (1)

Based on our discussion with the SIU manager, the restitution reported in the WSI Operating Report is calculated using two spreadsheets.

The first spreadsheet is maintained by the Collections department which includes payments received on employer fraud restitution determinations that is provided to the SIU department on a monthly basis.

The second spreadsheet is the "Restitution Master", which is maintained by the SIU department. On a monthly basis, the Accounting department provides a listing of all claims overpayments (non-fraud and fraud) to the SIU department. The SIU department then extracts all fraud payments made for each month and inputs the data into the "Restitution Master" spreadsheet.

The amounts included in the "Data from Management" column represent the recalculation of the total restitution from the underlying spreadsheets maintained by the SIU department. Differences noted in Table 3-5 represent unreconciled differences between the Quarterly Operating Report and the underlying spreadsheets.

Table 3-6: Reconciliation of Total Savings reported in the WSI Operating Reports during calendar years 2006 and 2007

	Operating Report	Data from Management	Difference
Fiscal Year Ended June 30, 2006:			
Quarter ended March 31, 2006	$ 284,767	$ 120,804	$ 163,963
Quarter ended June 30, 2006	903,486	192,990	710,496
	$ 1,188,253	$ 313,794	$ 874,459
Fiscal Year Ended June 30, 2007:			
Quarter ended September 30, 2006	$ 147,671	$ 147,671	$ -
Quarter ended December 31, 2006	151,403	151,403	-
Quarter ended March 31, 2007	299,732	290,697	9,035
Quarter ended June 30, 2007	293,785	293,785	-
Fiscal Year Ended June 30, 2007	$ 892,591	$ 883,556	$ 9,035
Fiscal Year Ended June 30, 2008:			
Quarter ended September 30, 2007	$ 111,848	$ 24,287	$ 87,561
Quarter ended December 31, 2007	222,255	309,816	(87,561)
	$ 334,103	$ 334,103	$ -

Based on our discussions with management, the total savings included in the WSI Operating Report should represent the amount that WSI would have paid out on fraudulent injured workers' compensation claims if the fraud had not been detected. The timing of when the

savings appears on the operating report is based on when the case is finalized and all appeals have been exhausted or settlement is reached.

For fiscal years ending June 30, 2007 and prior, the total savings includes cost avoidance from fraud investigations and field (non-fraud) investigations. Management made a decision to only report the cost savings from fraud investigations beginning with the fiscal year ending June 30, 2008. Based on our review of the WSI Operating Reports issued for the quarters ending September 30, 2007 and December 31, 2007, we did not note any documentation explaining the changes or its impact on the historically reported results (see Recommendation 3.4).

The amounts included in the WSI Operating Report for the quarters ending March 31, 2006 and June 30, 2006 were provided by the former SIU manager to the individual that prepared the report. Based on our discussions with management, SIU was making a transition during this time period in the manner in which the statistics were calculated. The information included in the "Data from Management" column represents the recalculation of the total savings using comparable detailed information for subsequent quarters. Based on the recalculated total savings, it appears that the WSI Operating Report overstated the savings from investigations.

The difference noted in the WSI Operating Report for the quarter ending March 31, 2007 represents an unreconciled difference to the specific case information maintained by the SIU department.

As noted above, Management made a decision to report only the cost savings from fraud investigations for the fiscal year ending June 30, 2008. The difference noted in the WSI Operating Report for the quarter ending September 30, 2007 is due to the fact that WSI erroneously included $87,561 for the cost savings from non-fraud investigations. Management corrected this error by understating the cost savings from fraud investigations for the quarter ending December 31, 2007 by $87,561. The year-to-date cost savings for the fiscal year ending June 30, 2008 as of December 31, 2007 was correctly reported.

Additional Test of the Accuracy of the Total Savings

In connection with Element Four, BDMP obtained a listing of the SIU fraud investigations associated with alleged injured worker fraud that were initiated during the calendar years 2006 and 2007. BDMP noted that there were investigations that resulted in a determination of fraud that did not include an estimate of the cost avoidance at the initial date of our fieldwork (4 in 2006 and 3 in 2007). Based on an updated analysis of these seven fraud investigations, the SIU Manager determined that four of the seven might have had cost avoidance that could have been reported as total savings on the WSI Operating Report. One of the seven investigations resulted in cost avoidance of $577,444 that was reported in the WSI Operating Report for the quarter ending June 30, 2008. The remaining two cases did not have any cost avoidance that should have been reported.

Methods & Process

Next, BDMP assessed the method and processes used to gather the data used to calculate the metrics currently included in the WSI Operating Report as well as the periodic monitoring reports routinely used by WSI to track organizational performance. This was accomplished via a detailed initial interview with the Quality Assurance Director responsible for compiling the Operating Report, followed by several follow-up dialogs and a review of the preparation directions and data sources.

Overall the methods and processes used to gather the information for the reports appear sound. Nearly 80% of the elements are gathered via automated reports tied either to the claims, document management or financial systems. Reliance on standard reports from these enterprise systems reduces the opportunity for user error from manually tracked statistics.

Approximately 20% of the metrics in the Operating Report are derived from queries run against user-maintained spreadsheets or local databases. Areas that appear to rely on these more manual tracking methods include:

- Measures relating to the Preferred Worker Program (PWP);
- Premium audits completed;
- Delinquent accounts;
- Hearings requested/held;
- Special Investigations Unit (SIU) metrics;
- WSI staff absenteeism and turnover rates; and
- System availability.

While these areas appear to be tracked using more manual processes, BDMP did not discover any discrepancies to suggest that there were errors in any of the relevant published metrics tied to these sources.

Due to the breadth and depth of the Operating Report, together with the fact that it is updated quarterly, BDMP found that WSI staff dedicated a significant amount of time to its preparation, review and final publication.

BDMP discovered one potential area of concern, related to the lack of a formal process to propose and approve changes to the calculated fields in the Operating Report. The example conveyed was a change in the method for calculating the Claim Acceptance Rate:

- After WSI implemented an Early Reporting Incentive plan designed to decrease the lag time for employers to report injuries, there was an increase in the number of "incident-only" claims being reported (i.e. claims with no medical care/bills). Ultimately these claims were closed in the WSI system as denials due to the lack of medical treatment

and/or the injured worker's failing to file a first report form. The Early Reporting Incentive program is described in more detail in Element 6, but the net effect of the plan on the Operating Report was to increase the number of administrative denials, thereby decreasing the reported overall Claim Acceptance Rate. This then led to questions about the overall claim denial trend.

- During one of the data quality reviews prior to publication of the Operating Report, when WSI senior management saw the impact of the administrative denials, they made a decision to change the calculation of the Claim Acceptance Rate (both in the current fiscal period and the two prior fiscal years included for trending purposes on the 2007 Operating Report) to exclude denials that could be related to the Early Reporting initiative. While this change is consistent with how other payers handle "incident-only" claims and was footnoted on the next Operating Report, there should have been a formal approval process in place to ensure that calculation changes are made only when appropriate, and that they are accompanied by supporting documentation explaining the rationale for the change and its impact on historical results.

Recommendations 3.4 and 3.5 suggest improvements to the Methods and Processes used to prepare the WSI Operating Report.

Validity of Metrics

In accordance with the second objective of Element Three, an assessment of the validity of the measures used by WSI to monitor their performance, BDMP began by evaluating recommendations put forth by the International Association of Industrial Accident Boards and Commissions (IAIABC) as well as the regular performance reports published by other monopolistic and competitive state funds or jurisdictional regulatory agencies.

In February of 2006 the Information Resources and Performance Measures Committee within IAIABC published a white paper entitled, "Workers' Compensation System Performance Measures: A Theoretical Framework and Practical Applications."[13] Their goal was to present a practical approach to measurement that would help individual jurisdictions measure their own progress toward desired ends, while also enabling them to benchmark themselves against other jurisdictions. The committee identified four major goals of workers' compensation systems:

1) Injury prevention;
2) Speedy, adequate, no-fault care;
3) Income replacement and return-to-work for injured workers, and;
4) Reduced risk to employers.

[13] Terrance Bogyo, Ann Clayton, Barry Hoschek, Mike Manley and Theresa Van Hoomissen, "*Workers' Compensation System Performance Measures: A Theoretical Framework and Practical Applications"*, (Madison, WI, IAIABC, 2006).

The committee then developed a series of recommended metrics designed to help measure and monitor progress toward those goals from an overall system perspective. A detailed list of the IAIABC recommended metrics can be found in Appendix B.

Although the focus of the IAIABC measures is clearly on evaluating overall system performance instead of measuring the performance of an individual claims payer, and since WSI functions as the entire workers' compensation system in North Dakota, many of the suggested measures appear to be relevant.

Before assessing the appropriateness of the WSI metrics, BDMP also interviewed key managers and reviewed the performance measures from other monopolistic and competitive state funds as well as regulatory agencies. The measures published by competitive funds and other large payers focused almost exclusively on standard financial statements. However, the other monopolistic funds and regulatory bodies provided core groups of metrics that were common across the multiple organizations, including WSI. Those measures included:

- Claim Volume/Frequency measures
    - Total Claims Filed
    - Indemnity Claims Filed
    - Claims Filed/100 Covered Workers
    - Indemnity Claims Filed/100 Covered Workers
    - Claims Acceptance (or Denial) rates
- Timeliness measures
    - Claim Reporting Lag Time
    - Claims Adjudicated within xx Days or Average Days to Adjudication
    - Percent of Initial Payments made within xx days
- Client/Population measures
    - Total Employer Accounts
    - Total Covered Workforce
    - Total Claims Cost per Covered Worker
- Claim Financials
    - Net Earned Premium
    - Administrative and Unallocated Loss Adjustment Expenses (ULAE) [total]
    - Indemnity Benefits Paid [total and/or per claim]
    - Medical Benefits Paid [total and/or per claim]
    - Allocated Loss Adjustment Expenses (ALAE) paid [total and/or per claim]
    - Total Paid Losses [total and/or per claim]
    - Total SIU savings and/or ROI

- Corporate Financials
    - Balance Sheet
    - Statement of Operations/Profit & Loss Statement
    - Statement of Cash Flows

There also were several measures that appeared regularly in the performance reports of other funds/agencies, but did not appear to be a part of WSI's current Operating Report. Those measures included:

- Average claim duration/days to close
- Lost workdays (either average lost workdays per claim or the gross total in the period)
- Percent of lost time claims for return-to-work (i.e. RTW success rate)

BDMP next reviewed the current WSI Operating Report to assess the validity and thoroughness of the measures used in North Dakota. The detailed measure definitions were reviewed and found to be reasonable and appropriate for the respective metric on the Operating Report. However, we noted that WSI publishes significantly *more* measures and more detailed performance data than other comparable state fund or regulatory agencies we reviewed. Specifically, BDMP compared the WSI Operating Report to the measures published by the state funds with the most comprehensive sets of measures publicly available as well as the comprehensive metrics utilized by all of the Canadian provinces. As illustrated in Table 3-7 on the following page, we determined that WSI publishes nearly three times as many measures as the next nearest comparable state fund or regulatory body reviewed.

The WSI Operating Report includes operational detail (E.g. average system availability / accessibility during core business hours, etc.) that exceeds what is available from other comparable payers or agencies. Thus, while these detailed metrics may be valid performance measures, many of them are more appropriately used for internal management reports rather than publicly posted performance reports.

Table 3-7 provides an overview of performance measures used by other organizations compared to WSI and BDMP's assessment each metric's appropriateness for either presenting corporate or departmental level.

Table 3-7: WSI Operating Report Measures Compared to Other Payers and BDMP Assigned Value

Performance Measure	ND (WSI)	WA	OH	MT	Canadian Provinces	Value of Measure at Organ. Level	Value of Measure at Depart. Level
Injury & Medical Services							
Total Claims Filed	X	X	X	X	X	High	High
Indemnity Claims Filed	X	X	X		X	High	High
Claims Filed/100 Covered Workers	X	X			X	High	High
Indemnity Clams Filed/100 Covered Workers	X	X			X	High	High
On-Line Claims as Percent of Total Claims Filed	X					Low	Medium
Auto-Adjudicated Claims as Percent of Total Claims Filed	X					Low	Medium
Percent of Claims Adjudicated w/in 14 Days	X		similar			High	High
Percent of Three Point Contacts Made w/in 24 hours	X					Medium	Medium
Claim Acceptance Rates	X	similar	similar		similar	High	High
Percent of Initial Indemnity Payments Made w/in 14 Days	X	similar			similar	High	High
Percent of Permanent Partial Impairment (PPI) Award Payments Made w/in 14 Days	X					Medium	High
Claims Pending Over 31 Days	X					High	High
Avg. New Claims per Claim Adjuster	X					Medium	High
Avg. Active Claims per Claim Adjuster	X					Medium	High
Avg. Active Auto-Adjudicated Claims per Adjuster	X					Low	Medium
Number of Active Permanently Totally Disabled (PTD) Claims	X					Low	Medium
Number of Claims Declared Permanently Totally Disabled	X					Low	Medium
Number of Vocational Rehabilitation Cases Closed (*claims filed prior to 1/1/06)*	X					Low	Medium

Table 3-7: WSI Operating Report Measures Compared to Other Payers and BDMP Assigned Value

Performance Measure	ND (WSI)	WA	OH	MT	Canadian Provinces	Value of Measure at Organ. Level	Value of Measure at Depart. Level
Number of Vocational Rehabilitation Cases Closed *(claims filed after 12/31/05)*	X					Low	Medium
Percent of Preferred Worker Program Participants Who Have Found Employment	X	similar				Low	Medium
Premium Dollars Saved by Employers with PWP Employees	X					Medium	Low
Amount of Wages Reimbursed for PWP Participants	X					Low	Medium
Dollars Spent on Worksite Modifications for PWP Participants	X					Low	Medium
Percent of Bills Received Electronically	X					Low	Low
Percent of Outstanding Bills Over 30 Days Old	X					Low	High
Days to Adjudicate Medical Bills	X					High	High
Employer Services							
Lag Time to Report Injuries	X		X			High	High
Total Active Employer Accounts	X	X	X	X	similar	High	Low
Number of Premium Audits Completed (includes phone audits)	X					Low	High
Delinquent Premium as Percent of In Force Premium	X					Low	High
Total Delinquent Premium - Accts in Active Collections	X					Low	Medium
Total Delinquent Premium - Accts Not Making Payments	X					Low	Medium
Legal/SIU							
Hearings Requested	X					Low	High
Hearings Held	X					High	High
Claimant Attorney Fees and Costs	X					Low	Medium
Office of Administrative Hearings (OAH) Fees	X					Low	Medium
WSI Counsel Fees and Costs	X					Low	High

Table 3-7: WSI Operating Report Measures Compared to Other Payers and BDMP Assigned Value

Performance Measure	ND (WSI)	WA	OH	MT	Canadian Provinces	Value of Measure at Organ. Level	Value of Measure at Depart. Level
Avg Days Hearing Request to Final Order (all orders)	X					High	High
Avg Days Hearing Request to Final Order (hearings only)	X					Low	Low
Office of Administrative Hearings (OAH) Avg Processing Days	X					Medium	High
Total Claim/Risk Field Investigation Costs	X					Low	High
Total SIU Investigation Costs	X					Low	High
Total SIU Budget	X					Low	High
Total Restitution	X					Low	High
Total Savings	X		X			Medium	High
SIU Return on Investment	X		X			Low	High
SIU Cases by Type	X					Low	High
Support Services							
Turnover Rate - All WSI Employees	X					Medium	Low
Absenteeism Rate - All WSI Employees	X					Low	Medium
Total Documents Indexed	X					Low	Medium
Avg. System Availability/Accessibility During Core Business Hours	X					Low	High
Finance							
(A) Net Earned Premium	X	X	X	X	X	High	High
(B) Paid Losses	X	X	X	X	X	High	High
(C) Covered Workforce	X	X			X	High	Medium
(D) Administrative and ULAE Costs	X	X		X	X	High	High
(E) FTE Authority	X					Low	High
(F) Claims with Activity	X					Low	Medium
Premium Cost per Covered Worker	X	X				High	High
Paid Claim Costs per Covered Worker	X		similar	similar		High	High
Administrative Cost per FTE	X					High	High

Table 3-7: WSI Operating Report Measures Compared to Other Payers and BDMP Assigned Value

Performance Measure	ND (WSI)	WA	OH	MT	Canadian Provinces	Value of Measure at Organ. Level	Value of Measure at Depart. Level
Administrative Cost per Claim	X		X	similar		High	High
Customer Satisfaction							
Employer Satisfaction	X					High	Low
Injured Worker Satisfaction	X					High	Low
Medical Provider Satisfaction	X					High	Low
Paid Cost Data							
Indemnity Benefits Paid	X	similar	X	similar		High	High
Medical Benefits Paid	X		X	similar		High	High
ALAE (all non-legal) Paid	X	similar			similar	High	High
ALAE (legal) Paid	X	similar				High	High
Total Paid Costs	X	X	X	X	X	High	High
Financials							
Statement of Financial Position							
Cash & Investments	X	X	X	X		High	Low
Premium Receivable	X	X	X	X	X	High	Low
Building & Other	X	X		X		High	Low
Total Assets	X	X	X	X		High	Low
Accounts Payable	X					High	Low
Unearned Premium	X					High	Low
Unpaid Loss & LAE (discounted at 5%)	X			X		High	Low
Total Liabilities	X	X		X		High	Low
Net Assets	X	X	X	X		High	Low
Total Liabilities & Net Assets	X	X		X		High	Low
Statement of Activities							
Earned Premium	X	X	X	X	X	High	Low
Premium Dividends	X	X	X	X		High	Low
Net Premium Earned (after dividends)	X	X	X	X		High	Low
Incurred Losses & ALAE	X	X		X	X	High	Low
General & Administrative Expenses	X	X		X		High	Low

Table 3-7: WSI Operating Report Measures Compared to Other Payers and BDMP Assigned Value

Performance Measure	ND (WSI)	WA	OH	MT	Canadian Provinces	Value of Measure at Organ. Level	Value of Measure at Depart. Level
Underwriting Income (Loss)	X			X		High	Low
Investment & Other Income	X	X	X	X		High	Low
Change in Net Assets	X	X	X	X		High	Low
Combined Ratio (fiscal year)	X					High	Low
Addl. Measures Not Included in WSI Operating Report	**0**	**7**	**11**	**4**	**18**		
Total Measures	**88**	**38**	**35**	**30**	**34**		

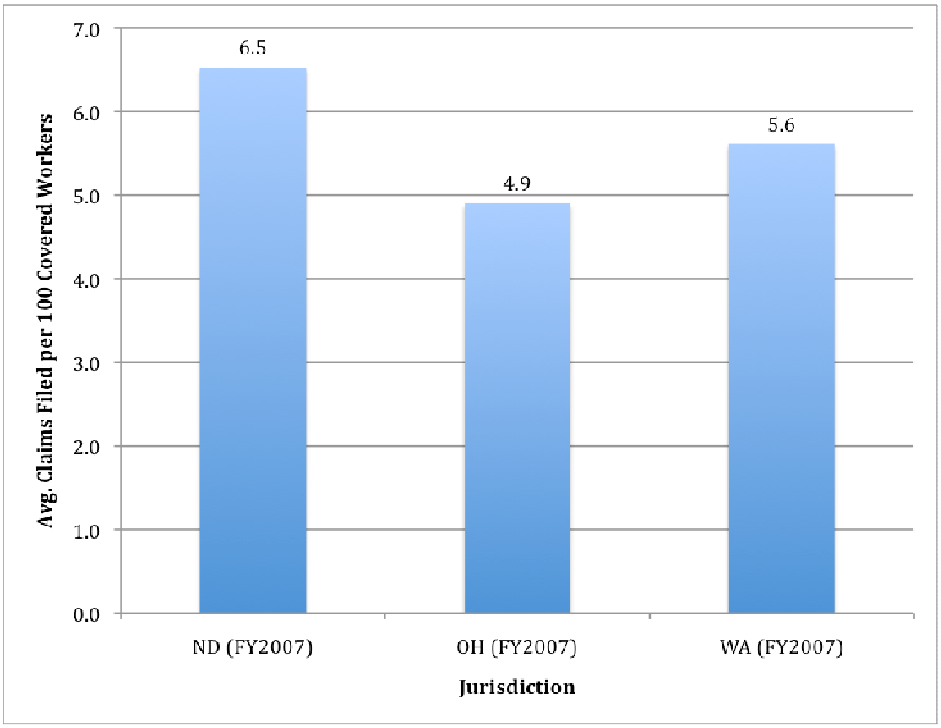
Recommendations 3.1 and 3.2 address the validity and value of the metrics included on the WSI Operating Report.

Benchmark WSI Performance compared to Other State Funds

BDMP attempted to benchmark WSI's performance against other state funds and large claims payers by both reviewing the comparisons already made by previous consulting reports and by comparing the measures shared across other state funds identified in Table 3-7 above to the results reported on the 12/31/2007 WSI Operating Report.

As illustrated below, North Dakota appears to have an above average claim frequency rate with the number of reported claims per 100 covered workers in ND nearly 24% higher than the published rates from other states with monopolistic state funds.

Figure 3-1: Average Claims Filed per 100 Covered Workers[14]

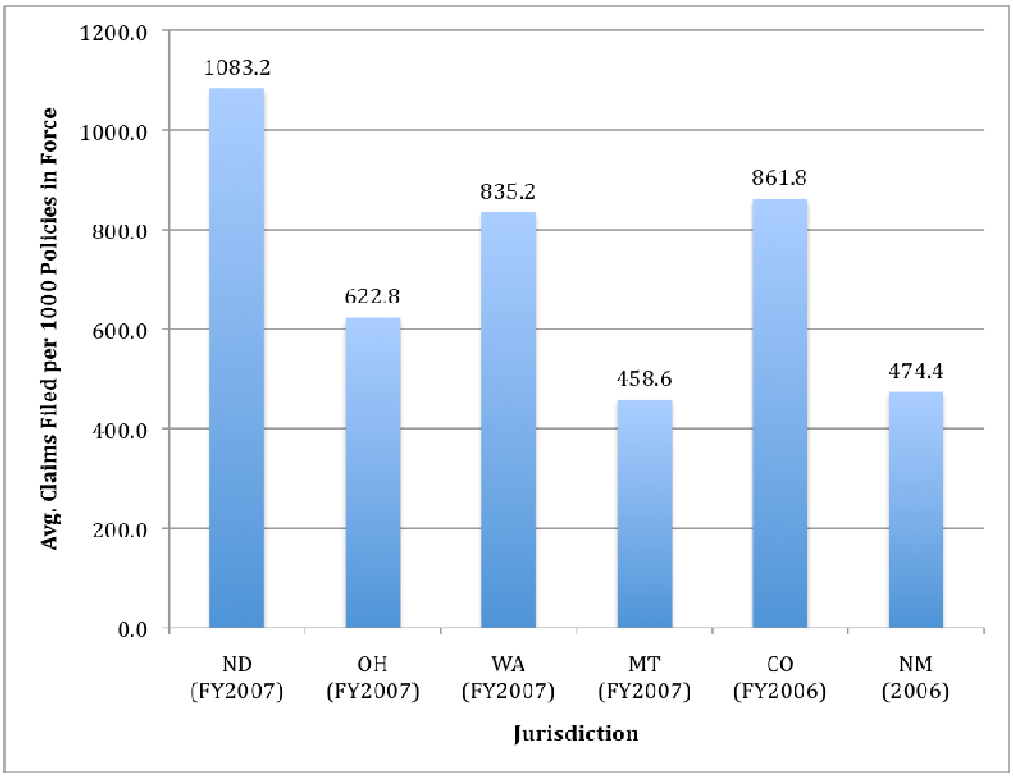


Similarly, using another common frequency measure, North Dakota had the highest number of reported claims per 1,000 employer policies in force when compared to a broader range of state funds.

[14] Sources included:

- Workforce Safety & Insurance, *WSI Operating Report as of the Quarter Ending 12,31,2007*, http://www.workforcesafety.com/library/documents/reports/OPRpt-Board123107.pdf
- Ohio Bureau of Workers' Compensation, *Fiscal Year 2007 Annual Report*, http://www.ohiobwc.com/downloads/blankpdf/AnnualReport.pdf
- Washing State Department of Labor & Industries, *2007 Annual Report*, http://www.lni.wa.gov/IPUB/101-080-000.pdf

Figure 3-2: Average Claims Filed per 1,000 Policies in Force[15]



WSI's fiscal year 2007 average of 1,083.2 claims filed per 1,000 policies in force was 20% higher than the next highest state fund (CO) and nearly 40% higher than the average of all the other funds studied. It is difficult to draw meaningful conclusions from the raw frequency statistics across multiple jurisdictions since injury frequency is largely a function of the worker's occupation and the major types of employment in each state vary dramatically.

However, BDMP's evaluation of the Safety Grant programs (Element 1) suggests that WSI invests significantly more money in safety and injury prevention programs than other states.

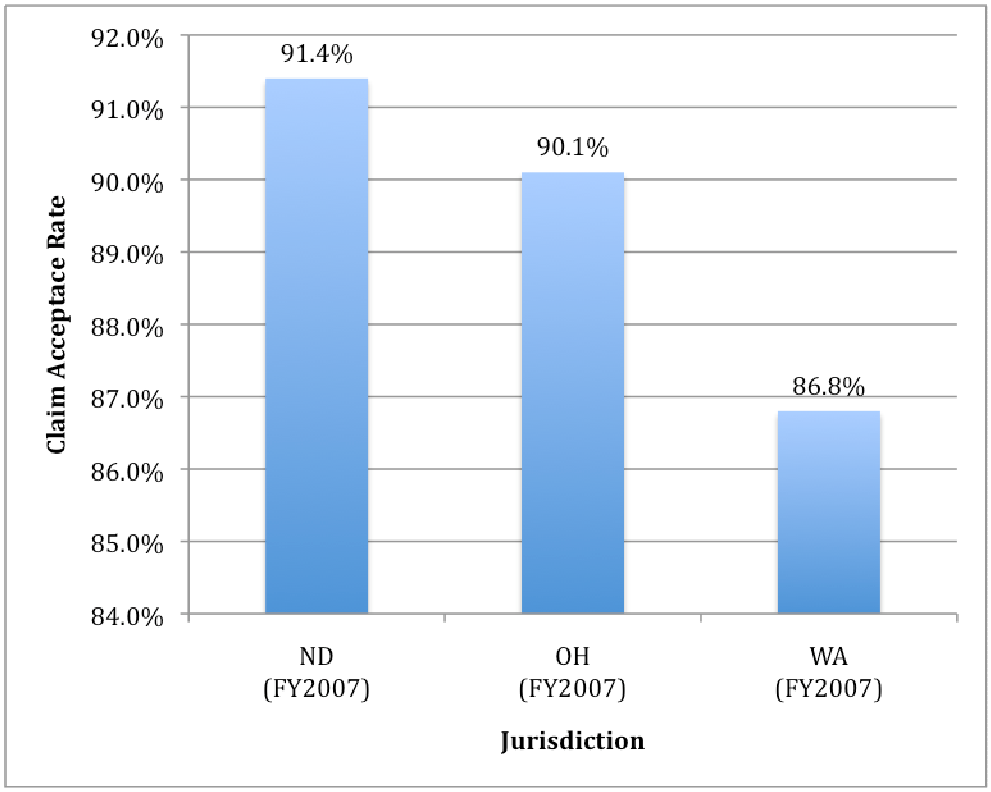
[15] Sources included:

- Workforce Safety & Insurance, *WSI Operating Report as of the Quarter Ending 12,31,2007*, http://www.workforcesafety.com/library/documents/reports/OPRpt-Board123107.pdf
- Ohio Bureau of Workers' Compensation, *Fiscal Year 2007 Annual Report*, http://www.ohiobwc.com/downloads/blankpdf/AnnualReport.pdf
- Washing State Department of Labor & Industries, *2007 Annual Report*, http://www.lni.wa.gov/IPUB/101-080-000.pdf
- Montana State Fund, *2007 Annual Report*, http://www.montanastatefund.com/ilwwcm/resources/file/eb9a0c04df863ab/Master_AnnualReport_2007.pdf
- Pinnacol Assurance, *2006 Annual Report*, http://www.pinnacol.com/aboutpinnacol/documents/2006_Pinnacol_AR_marketing_002.pdf
- New Mexico Mutual, *2007 Annual Report to Governor Richardson and the Legislative Committee*, October 1, 2007, http://www.nmmcc.com/images/resources/537/2007%20LFC%20Report.pdf

Yet, despite this investment, North Dakota's injury frequency remains the highest among the states studied.

North Dakota's above average claim frequency does not appear to be leading to a greater number of denied claims, as WSI actually had the highest initial claim acceptance rate among the funds reporting on denials as illustrated in Figure 3.3 below.

Figure 3-3: Initial Claim Acceptance Rates[16]

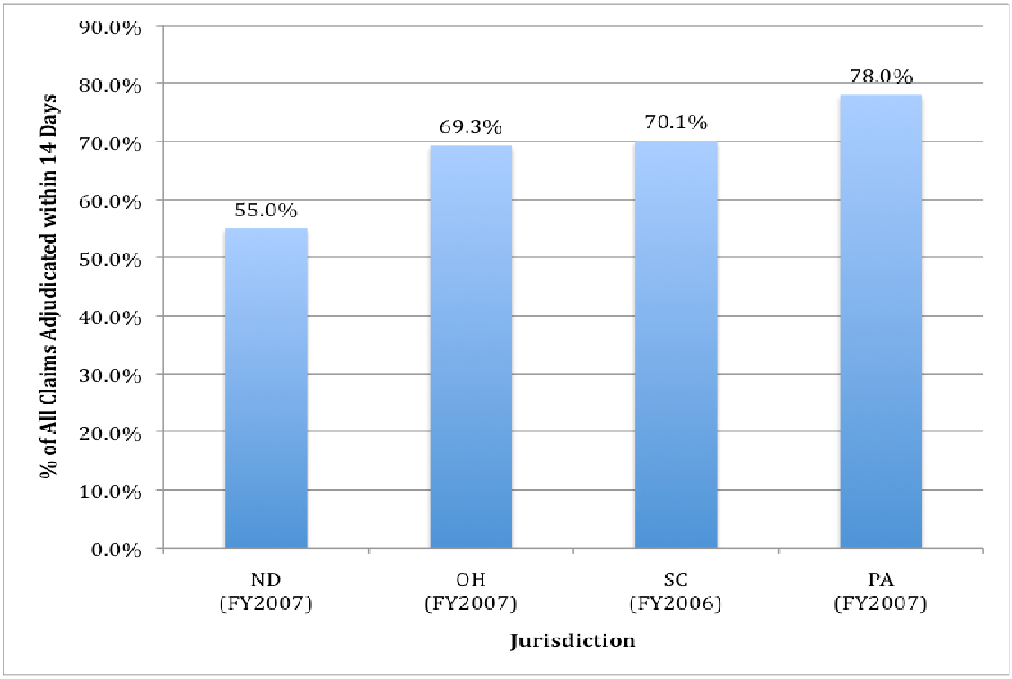


[16] Sources included:

- Workforce Safety & Insurance, *WSI Operating Report as of the Quarter Ending 12,31,2007*, http://www.workforcesafety.com/library/documents/reports/OPRpt-Board123107.pdf
- Ohio Bureau of Workers' Compensation, *Fiscal Year 2007 Annual Report*, http://www.ohiobwc.com/downloads/blankpdf/AnnualReport.pdf
- Washing State Department of Labor & Industries, *2007 Annual Report*, http://www.lni.wa.gov/IPUB/101-080-000.pdf
- Montana State Fund, *2007 Annual Report*, http://www.montanastatefund.com/ilwwcm/resources/file/eb9a0c04df863ab/Master_AnnualReport_2007.pdf

However, it does appear to take WSI slightly longer than the average state fund to make the initial compensability decision, as illustrated in Figure 3-4 below.

Figure 3-4: Percent of All Claims Adjudicated within 14 Days[17]



Conclusions

At the conclusion of the evaluation activities outlined above, BDMP determined the following:

Accuracy of Claims Metrics

We did not identify any significant issues with the accuracy of the claims metrics included in the WSI Operating Reports. BDMP was able to independently verify the accuracy of several other key claims organizational metrics using data supplied to support the claim reviews.

[17] Sources included:

- Workforce Safety & Insurance, *WSI Operating Report as of the Quarter Ending 12,31,2007*, http://www.workforcesafety.com/library/documents/reports/OPRpt-Board123107.pdf
- Ohio Bureau of Workers' Compensation, *Fiscal Year 2007 Annual Report*, http://www.ohiobwc.com/downloads/blankpdf/AnnualReport.pdf
- South Carolina State Accident Fund, *State Accident Fund 2007 Accountability Report*, http://www.saf.sc.gov/Eng/Public/Aboutus/AcctReport.doc
- Pennsylvania State Workers' Insurance Fund, Frequently Asked Questions, http://www.dli.state.pa.us/landi/cwp/view.asp?a=151&q=209772

Accuracy of Legal/SIU Metrics

During our testing of the Legal/SIU statistics, we noted unreconciled differences in the information reported and changes in the underlying definition of the statistics for the information reported during the calendar years ending 2006 and 2007. We also noted that certain injured worker investigations that resulted in a determination of fraud were not included in the total savings reported in the WSI Operating Report. The information presented in the WSI Operating Report for Legal/SIU is not gathered via automated reports (see recommendation 3.5). The opportunity for error is increased by the fact that the information is based on manually tracked statistics. Based on our testing, it does not appear that the information provided by the SIU department is verified by an individual outside of the SIU department. Due to the opportunity for error, we recommend that the Internal Audit department perform a documented review of the information provided by the SIU department for inclusion in the WSI Operating Report (see Recommendation 3.6)

Accuracy of Financial Data

The financial data included in the Operating Report matched the results reported in the audited financial reports.

Methods & Process

Overall, the methods and processes used to gather the information for the Operating Reports appear sound. Nearly 80% of the data elements are gathered via automated reports tied directly to the claims, document management or financial systems. Reliance on standard reports from these enterprise systems reduces the opportunity for user error from manually tracked statistics. BDMP also did not find any areas of concern with the remaining 20% of metrics that depend on user-maintained spreadsheets or databases.

- While there is a sound process in place to collect all of the required data each quarter, a similar formal structure does not appear to exist regarding changes to calculations used for the Operating Report. BDMP learned of several instances in which WSI senior managers decided unilaterally to change the way specific metrics in the Operating Report were calculated. While these calculation changes were typically in response to underlying operational or workflow changes and were usually noted in footnotes within the respective Operating Reports, there was not sufficient documentation accompanying each change explaining the rationale for the new calculation or its impact to historically reported results.

Validity of Metrics

- All of the metrics included in the WSI Operating Report represent valid measures of performance in one form or another. However, many of those measures appear to be

more appropriate at a departmental level rather than a valid indicator of overall organizational performance.

- WSI includes nearly three times the number of metrics used by comparable state funds and the measures used for WSI's Operating Report are typically at a much more granular level than those used by other payers.

- Despite having a greater number of metrics than the other groups reviewed, WSI did not include certain metrics that are common to the other funds/payers, including:

    - Measures of average claim duration
    - Measures of lost workdays (either average per claim to gross total)
    - Measures of injured worker return-to-work success

Benchmarking WSI Performance against Other State Funds

- North Dakota appears to have a higher claim frequency than other states with monopolistic state funds. North Dakota's rate of 6.5 claims filed per 100 covered workers is 24% higher than the published rates from the states of Ohio and Washington.

- North Dakota also had the highest average number of claims filed per 1,000 policies in force (1,083.2), which was 20% higher than the nearest other state fund (CO) and nearly 40% higher than the average of all the other funds studied.

- Despite these above average statistics for claims filed, WSI appeared the least likely of the state funds studied to deny a claim. Ninety-two percent (92%) of all fiscal year 2007 ND claims filed were initially accepted compared to an average of 88.4% for the other monopolistic state funds that published denial statistics (OH, WA).

- It does appear to take WSI longer to make an initial compensability decision as only 55% of all Fiscal Year 2007 claims were adjudicated within 14 days versus an average of 72.5% for the other state funds reviewed.

Recommendations

Recommendation 3.1: Focus the Board's attention on the most important WSI performance measurements. (High)

The WSI Board currently uses a quarterly Operating Report that includes nearly 100 performance metrics. This number of topics cannot be adequately discussed and assessed during the course of a one-day Board meeting. It also is nearly three times the number of organizational metrics utilized by comparable state funds or other large payers.

A more effective approach would be to carefully select a small number of very important strategic metrics that inform the Board on issues deemed essential to WSI operations, trends and Board decision-making. A more manageable, balanced scorecard system typically involves only 15-25 metrics.

WSI Response: CONCUR

The Operating Report is a management report as well as a report that is presented to the Board.

Currently, WSI Management is in the process of developing a more refined set of key performance indicators that will provide a quick glance of WSI operations. These performance indicators will be presented to the Board at their regular meetings as part of the CEO update.

Under Policy Governance®, primary reporting to the Board will be through the CEO monitoring reports for the Board Executive Limitations and Ends policies, as well as reporting on the progress of the strategic plan.

Recommendation 3.2: Provide adequate training and support for Board members to help them fully comprehend critical organizational performance measures. (Medium)

In order to maximize the value of having the Board review and discuss the organizational performance metrics, WSI should provide training and support materials to ensure that all members fully understand the intent, source, definition/derivation and value of each measure. In addition, the training and documentation materials should provide users of the Operating Report with expected or target values for each metric and a clear explanation of whether higher or lower values would indicate better performance.

WSI Response: CONCUR

WSI currently has a document that is presented to all new board members. Updates are also provided to current board members when changes are made to it. This document describes how each measure and projection is calculated and how each target is derived. This document will be revised to include the importance, intent, definition and source of each measure.

Recommendation 3.3: Benchmark performance against national standards in the workers' compensation industry more frequently. (Medium)

BDMP's review of Board meeting records, operating reports, and Board member interviews indicate that WSI performance is not regularly compared to national averages and standards. The Board should seek agreement and buy-in from key stakeholders (including the Governor's Office and Legislature) with regard to a set of key performance metrics that will be used by all parties in evaluating WSI's performance.

These metrics should be compared against a national standard in order to ensure that an appropriate perspective is afforded the results.

For example, WSI already has one potential benchmarking tool available in the Official Disability Guidelines (ODG). As noted in Element Six, WSI has successfully integrated the evidence-based clinical and disability guidelines into the standard claims process. The next logical step would be for WSI to begin to leverage ODG use into organizational benchmarking, providing comparisons to national norms for claim and disability durations.

In addition, WSI should consider participating in the annual CompScope™ Multistate Benchmark studies published by the Workers' Compensation Review Institute as one method to quickly compare their organization's performance against other workers' compensation systems.

WSI Response: CONCUR

Currently, WSI Management is in the process of developing a set of performance indicators that will provide a quick glance of WSI operations. Key measures will support the strategic plan as well as board monitoring reports. WSI will continue to research sources for industry benchmarks that will provide for comparison with other workers' compensation systems. Regional comparisons which may provide more relevant data will be researched as well.

Recommendation 3.4: Develop a formal process to approve future changes to the Operating Report. (High)

While it is expected that future regulatory, system or operational workflow changes will make it necessary for WSI to add or delete metrics as well as revise specific calculations, those proposed changes should be reviewed and approved by the Audit Committee or the full WSI Board to ensure complete transparency to the process. The addition, deletion or revision of metrics also should be accompanied by supporting documentation explaining the rationale for the change and its impact on historical results.

WSI Response: CONCUR

A formalized process will be created to approve changes to the Operating Report. The need for the change will be presented to the Executive Team for their approval. The Audit Committee will receive notice of all changes made to the Operating Report.

Recommendation 3.5: Automate the preparation of as many metrics as possible following the migration to a new claim system. (High)

While the majority of Operating Report metrics are currently tracked via automated reports, there are several areas that still require manual tracking and reporting by WSI

staff using spreadsheets or local databases. As WSI migrates to a new claim system, this would be an appropriate time to evaluate which performance metrics will be required and ensure that the system can track and generate as many of them as possible via automated reports. As WSI finalizes their key performance metrics going forward, those requirements should be shared with the system migration team to ensure that all reporting and information needs will be met.

WSI Response: CONCUR

To the extent currently possible metrics are automated and run through standardized reports. It is the intent of WSI that within the next two years the new computer system will allow for the automation of all metrics gathered for all monitoring reports.

Recommendation 3.6: Perform a documented review of the information provided by the SIU Department that is included in the WSI Operating Report. (High)

The information presented in the WSI Operating Report for Legal/SIU is not gathered via automated reports. The opportunity for error is increased by the fact that the information is based on manually tracked statistics. Based on our testing, it does not appear that the information provided by the SIU department is verified by an individual outside of the SIU department. Due to the opportunity for error, we recommend that the Internal Audit department perform a documented review of the information provided by the SIU department for inclusion in the WSI Operating Report (see Recommendation 3.5)

WSI Response: CONCUR

It is the intent of WSI that within the next two years the new computer system will allow the SIU to gather the required information via automated reports. In the meantime WSI's Internal Audit department will conduct a documented review of SIU data submitted for inclusion within WSI's Operating Report.

Element 4: Evaluation of Fraud Expenditures

Objective

Element four required an evaluation of the effectiveness of the fraud expenditures in accordance with NDCC Section 65-02-23. As part of this process, we reviewed background documentation to identify the number of investigations in calendar years 2006 and 2007 that involved employer, provider, and injured worker fraud. In addition, we benchmarked WSI's fraud expenditure and areas of occurrence (employer, provider, and injured worker fraud) against peer states and large insurance organizations for this same time period.

Key Activities

To conduct this analysis, BDMP undertook the following activities:

- Reviewed North Dakota State Statute 65-02-23 regarding WSI's Special Investigations Unit (SIU);
- Obtained listings of injured worker, provider and employer investigations during calendar years ending December 31, 2006 and 2007 from the SIU department;
- Discussed the process and procedures to determine which claims are selected for fraud investigations with management;
- Obtained a summary of the restitutions and savings from investigations that uncovered instances of fraudulent activities;
- Obtained a listing of the fraud expenditures tracked by WSI for the years ending December 31, 2006 and 2007 from management; and
- Compared fraud activities and statistics against other monopolistic workers' compensation jurisdictions and large insurance organizations.

Background

Fraud is defined as intentionally misrepresenting or misleading for purposes of financial gain. In workers compensation this usually takes the form of: an employer not paying the workers' compensation premiums they should pay; an employee taking benefits they are not entitled to under the workers' compensation act; health care providers, vocational providers, or attorneys billing for more services, a more costly level of service then provided, or billing for services they have not rendered. The SIU is primarily responsible for the detection, investigation and

recovery of fraudulent payments made and the non-payment of premiums owed but not paid due to fraud. The SIU staffs a fraud email and telephone hotline for referrals from members of the public and obtains investigative assignments from the claims department.

Workers compensation fraud is a significant problem for both employers and workers. Legitimate businesses may be put at a significant cost disadvantage when competing against illegitimate businesses that underpay or do not pay at all. Fraudulent workers hurt both their employers and co-workers. Increased spending on fraudulent claims means fewer resources to commit to new jobs, better equipment, or better worker benefits. Given the impact of fraud on business and workers, the detection and deterrence of fraud represents an important opportunity for North Dakota.

At the beginning of the biennium, WSI staffed as many as five employees. However, at the time of BDMP's performance evaluation, there was only one staff remaining with a Special Assistant Attorney General functioning as the SIU manager. Sometime during or after 2005, SIU began performing compensability (field) investigations for the Claims Department.

Currently, the majority of fraud investigations for injured workers are initiated by claims adjusters. Employer and provider fraud investigations are initiated from tip-lines (both telephonic and electronic). According to the acting manager of SIU, very few of the employer fraud cases are investigated at present. At the time of our review he was in the process of meeting with the Policyholder Services Division (PHS) to determine why and how to get it started. He had mentioned one case in particular they had referred to the premium fraud unit weeks ago with no results that he was aware of.

Based on our conversation with the current SIU manager, previous managers of SIU and PHS did not get along professionally or personally due to differences in management philosophies and personalities. This personality conflict led to a divide between SIU and PHS departments that has continued to exist. In addition, it appeared from our review that premium audit had been understaffed to perform the premium audits they were being asked to undertake even without the additional employer fraud referrals, this may also explain why very few of the employer fraud referrals were investigated by that unit. The former PHS manager made a decision that all employer fraud investigations be referred to the premium audit unit, which was supported by upper management of WSI. Because of management's decision for employer fraud to be investigated by the premium audit unit, SIU has investigated and pursued few employer fraud cases during this biennium and does not appear to have an overall strategy on how to identify provider fraud. (See Recommendation 4.2)

The 2004 performance evaluation included a recommendation that an increased emphasis should be made to develop a proactive provider fraud and employer fraud program. The 2006 performance evaluation included a recommendation that WSI investigate medical provider fraud more thoroughly. Based on our analysis of prior recommendations in connection with

Element 5, these two recommendations have not been implemented by WSI. (See Recommendation 4.2)

It is our understanding that the members of the PHS department that are conducting fraud investigations have not received formalized training in fraud investigation techniques and potential flags that could provide an indication of fraudulent activities. (See Recommendation 4.4) In most cases where PHS department employees are involved in fraud investigations, the SIU manager oversees the process.

This situation is evident by the decrease in the total restitution and savings reported in the key performance indicators report: 14% between fiscal year 2005 ($1,199,607) and fiscal year 2007 ($1,029,799) and 37% from fiscal year 2006 ($1,646,650) to fiscal year 2007 ($1,029,799).

At the time of the performance review, the SIU acting manager and PHS began discussions to see if the split responsibilities and previous poor internal relationship could not be resolved for the effective investigation of employer fraud. (See Recommendation 4.3)

Findings and Observations

Based on information provided by management, the number of fraud investigations conducted by WSI and instances of fraud discovered by areas of occurrence, and the related restitution and cost avoidance for the investigations initiated during calendar years 2006 and 2007 is presented in Table 4-1. The information presented in Table 4.1 includes the determination of cost avoidance through June 30, 2008 from fraud discovered from the investigations initiated during calendar years 2006 and 2007.

Table 4-1: 2006 & 2007 WSI Summary of Fraud Investigations and Discoveries

	Number of Investigations	Pending Investigations	Fraud Discovered	Cost Avoidance/ Premium Recovered
2006 WSI Fraud Data				
Employer	35	-	10	$ 78,618
Provider	18	-	-	-
Injured Worker	47	5	11	89,223
2006 Total	**99**	**5**	**21**	**$ 167,841**
2007 WSI Fraud Data				
Employer	19	-	3	$ 727
Provider	14	1	-	-
Injured Worker	29	-	11	673,553
2007 Total	**61**	**1**	**14**	**$ 674,280**

The cost for investigators used to perform the external fraud investigations amounted to $40,568 and $14,728 for calendar years 2006 and 2007. WSI does not separate the internal SIU costs between the activities associated with performing fraud investigations and any non-fraud investigations. The quarterly operating report includes the entire SIU budget in the calculation of the return on investment. As a result, it appears that the return on investment reported in the WSI key performance indicators may be understated. (See Recommendation 4.1)

Most workers compensation fraud is committed by employers, workers, health care providers and attorneys but instances have been found of insurance adjuster fraud and worker relative fraud as well. The jurisdictions that appear most successful at finding and prosecuting worker compensation fraud generally use a multi-agency approach.[18] This would often involve investigative collaboration and data sharing arrangements with the state agencies of revenue, business licensing, job service, attorney general and the state prosecutors. Within an insurance organization the claims department, premium or payroll audit, information technology, legal services and a special compliance or fraud until (like SIU) are at the lead of most investigations and develop the overall strategy from which they obtain support from the rest of the organization.

Table 4-2 below compares North Dakota fraud results to other monopolistic workers compensation jurisdictions and one large insurer in Texas. While not exact, these statistics are useful for demonstrating improved results are possible and how little WSI as an organization

[18] See examples of multi-agency task forces and fraud efforts in the states of: California, New York, Ohio, and Washington. Two example fraud reports are also included in the appendices.

accomplishes in pursuing employer fraud. Note that the highlighted rows from Table 4-2 are used to draw conclusions.

Table 4-2: Comparison of WSI Fraud Results to Other Organizations

	British Columbia[19]		North Dakota[20]		Ohio[21]		Texas Mutual Insurance Company[22]		Washington[23]	
	FY-06	FY-07	FY-06	FY-07	FY-06	FY-07	FY-06	FY-07	FY-06	FY-07
Number of Investigations	765	694	99	125	6121	5963	1540	1484	4479	4900
% Emp.	NR	NR	16%	9%	NR	11%	NR	NR	NR	NR
% Worker	NR	NR	36%	17%	73%	78%	NR	NR	NR	NR
% Other[7]	NR	NR	48%	74%	NR	8%	NR	NR	NR	NR
Identified Instances of Fraud	3	1	NR	NR	85	111	16 convic-tions	17 convic-tions	20	13
% Emp.	NR	NR	NR	NR	NR	NR	25%	18%	NR	46%
% Worker	NR	NR	NR	NR	NR	NR	50%	77%	NR	31%
% Other[24]	NR	NR	NR	NR	NR	NR	25%	6%	NR	2%
Total Recoveries (and/or costs avoided) (In Millions)	**$8.97**	**$6.59**	**$1.65**	**$1.03**	**$90.7**	**$100.0**	**$16.0**	**$12.2**	**$135.3**	**$139.2**
% Emp.	NR	NR	NR	NR	NR	NR	**76%**	**66%**	NR	**96%**
% Worker	NR	NR	NR	NR	NR	NR	**24%**	**34%**	NR	**4%**
% Other	NR	NR	NR	NR	NR	NR	NR	NR	NR	**1%**
ROI (operational costs divided by recoveries)	NR	NR	4.05 to 1	2.9 to 1	7.8 to 1	8.3 to 1	NR	NR	10.2 to 1	9.8 to 1

NR – Information not reported by organization

[19] Figures obtained from Terry Bogyo, Director of Planning for WorksafeBC. Amounts are stated in Canadian dollars.
[20] North Dakota figures taken from the Quarterly Operating Reports.
[21] Ohio figures taken from *Ohio Special Investigations Unit: 2007 Annual Fraud Report*. The Ohio figures are stated as "fraud dollars identified" with no specific definition.
[22] Texas Mutual figures taken from tables at www.texasmutual.com/fraud/fightFraud.shtm . Number of investigations are understated as they only reported the number of claimant referrals investigated and not the number of employer or other investigations undertaken.
[23] Figures obtained from Washington Labor and Industries *2007 Annual Fraud Report to the Legislature.* Appears Washington includes the costs of premium auditors and the additional premiums they assess as a result of their premium audits in the recovery and return on investment figures.
[24] Other categories of fraud include provider, attorney and claims adjuster fraud. North Dakota's other category includes 44% and 71% of claim/field investigations that SIU staff worked instead of outsourcing to private investigators for fiscal years ending June 30, 2006 and 2007, respectively.

Conclusions

At the time of BDMP's performance evaluation, the SIU was understaffed and their relationship with PHS was eroded to the point that few employer and provider fraud investigations were being completed. In general, the SIU was not resourced, empowered, or otherwise conducting activities to investigate and recover monies from fraudulent employers and payors. When used appropriately, the SIU could become a powerful protector of WSI stakeholder interests through its collaboration with other internal and external organizations to identify, investigate, and prosecute fraudulent claims. The current lack of SIU cost information makes it difficult to prove the value of the SIU's role by demonstrating a positive return on investment.

An audit plan should be developed for identifying which cases should be investigated for provider and employer fraud. There has been a decrease in the number of investigations of both potential employer and provider-related fraud. Specifically, in 2006, the 34 employer fraud investigations resulted in additional payments of approximately $78,618 to WSI. In 2007, the 19 employer fraud investigations only resulted in additional payments of approximately $727.

Recommendations

The following recommendations are the result of our combined observations, interviews, research and knowledge of other jurisdictions, and experience in previous engagements.

Recommendation 4.1 Track staff time and costs associated with fraud investigations. (Low)

WSI would benefit from implementing a more rigorous process for identifying, tracking, and reporting on time and costs related to fraud prevention and prosecution. It is difficult to defend the value of an activity unless there is a clear, understandable metric such as financial return on investment. Without this information, it will be more difficult for WSI management to demonstrate the value of a robust fraud program and get the support in personnel and funds needed to maintain this program.

Additionally, fraud expenditure information should be tracked by employer, provider and injured worker investigation so that this information may be used to better understand cost risks posed by different entities.

WSI Response: PARTIALLY CONCUR

The goal here is an accurate report of the SIU's return on investment (ROI) that is defendable and ultimately justifies the existence of the SIU in monetary terms. WSI agrees that it would benefit from implementing a more rigorous process. It is the intent of WSI that within the next two years the new computer system will allow the SIU to gather the required information via automated reports. If this occurs, tracking costs of SIU activities will become less burdensome and better metrics can be established.

WSI only partially concurs with this recommendation because it suggests that staff time should be tracked. Before the BDMP evaluation was begun, WSI had considered this approach and decided against it because of how it would tax staff time. WSI will consider periodically tracking staff time in order to better estimate the amount of resources expended on non-fraud as opposed to fraud investigations.

WSI is already able to track fraud expenditure information by the type of the investigation (provider, employer, etc.) and anticipates using this ability to review efficiencies

Recommendation 4.2 Increase focus on conducting provider and employer fraud investigations and strengthen collaboration between internal and external organization. (High)

The SIU department, PHS, and Utilization review and bill review sections along with the claims units should work more closely together to identify claims that may involve employer or provider fraud. Additionally, using their data on payments to providers coupled with staff knowledge with providers resulting from utilization and bill review investigations would improve the identification of potential provider fraud. As mentioned in the Safety section, the listing of members of associations applying for safety grants should also be matched against the PICS database to determine if any of the association members do not have a WSI policy and further investigations made as necessary.

In addition, WSI should explore collaborative approaches with the Unemployment office, Revenue and other agencies within North Dakota that would help identify new employers for WSI to contact to ensure they purchase coverage. According to our interviews, there had been some discussions with unemployment compensation with the result of database matching problems. Further collaboration could reduce this problem as other jurisdictions have sought and been successful in reducing these barriers successfully. The states of Ohio and Washington provide good examples of successful collaborations.

WSI Response: CONCUR

WSI's investigation of employer fraud is undergoing necessary changes. Utilizing "Continuous Service Improvement" training and concepts, members of SIU and PHS and internal facilitators met several times over the summer. Our mission was to improve the process for handling reports of employer fraud or non-compliance by defining ownership and responsibilities and implementing a uniform and timely procedure. That mission was recently completed and reports of employer fraud or non-compliance are being acted upon more promptly and uniformly. The new process was gradually implemented beginning in May 2008. Collaboration is the key to the process with the SIU now meeting regularly with staff from the Premium Audit,

Underwriting and Collections units to form a new "noncompliance team" that takes action or plans for each referral. Since the changes, at least ten referrals have been opened for investigation or review (during the previous six months there were zero referrals).

WSI will continue to develop collaborative processes; specifically those that include cross-checking data-bases of other agencies for employers that may be reporting to one agency but not another.

As for this recommendation's reference to medical provider fraud, WSI agrees with that it should increase its presence. WSI has and will continue to investigate medical provider fraud cases reactively, and is now focused on developing an approach to investigate proactively. To do so, it must explore the possibility of purchasing a product or service that will data-mine provider billings using computer software. In June of 2008, WSI issued a Request for Information to obtain more knowledge on this topic and has now begun to draft a Request for Proposal to solicit bids for a pilot project. Interestingly, the state of Washington has recently purchased such a product to use under a pilot project and they have graciously shared much information with us.

Recommendation 4.3 SIU should leverage PHS in determining which employer investigations should be performed. (High)

The majority of the employer fraud leads come to WSI from tip lines. If WSI management has decided these investigations should be conducted by PHS, PHS should be accountable for completing these investigations and reporting the results and related operational costs to the SIU manager.

However, if PHS is not able to investigate these complaints within a reasonable period of time, the SIU should be staffed and authorized to investigate these complaints to their satisfactory conclusion. If the public senses no employer fraud activity being pursued by WSI, the number of complaints and "tips" will decrease, making it even more difficult for WSI to detect and locate employer violators.

WSI Response: CONCUR
Please see WSI's response to recommendation 4.2

Recommendation 4.4 PHS employees should receive training in order to conduct effective fraud investigations. (Medium)

We recommend that PHS employees involved with fraud investigations receive the appropriate training in fraud investigation techniques and potential flags that could provide an indication of fraudulent activities.

WSI Response: CONCUR

Appropriate training will be provided in the future.

Element 5: Review of Previous Performance Evaluation Recommendations

Objective

Element Five requested BDMP evaluate the implementation status for the 109 recommendations made as part of the 2006 Performance Evaluation (PE2006).

Key Activities

BDMP undertook the following activities for Element Five:

- Reviewed Internal Audit and Quality Assurance work papers and records related to PE2006 recommendations;
- Reviewed 2006 and 2007 Internal Audit Programs;
- Reviewed other consulting reports and audits that addressed recommendations;
- Reviewed quarterly, committee, and special Board meeting minutes taken during the evaluation period;
- Interviewed WSI managers and staff; and
- Reviewed other supporting documents where applicable to specific recommendations (e.g., ad hoc reports, correspondence, research analysis, etc.).

BDMP conducted the activities listed above to understand the current status of recommendations made during the 2006 Performance Evaluation.

Additionally, each BDMP team member carefully evaluated 2006 recommendations that fell within the 2008 Performance Evaluation element area to validate the feedback provided by WSI Based on our review and findings (Appendix C), we evaluated the status of each recommendation and categorized them as either Fully, Partially, or Not Implemented. Appendix C includes BDMP's assertion as to the PE2006 recommendation status and a short narrative explaining the evidence and circumstances used to support our assertion.

Observations & Findings

Regarding PE2006 Recommendations

Detailed observations and findings regarding the status of recommendations made as part of the 2006 Performance Evaluation are presented in Appendix C.

Regarding Internal Audit and Controls in Regards to Prior Recommendations

The following observations and findings address issues related to WSI internal process for implementing and tracking prior recommendations that we believe are relevant to this analysis.

- BDMP observed from board meeting minutes that the Quality Assurance Manager (QAM) and Internal Audit staff regularly update the WSI Board on the status of implementing consultant recommendations. The review of prior recommendations is a regular item on meeting agendas.

- BDMP observed that the QAM assigned a "percent complete" to recommendations in order to communicate progress to interested parties (board and management). However, BDMP noted that the "percent complete" field was typically not an accurate reflection of the recommendation status and we did not rely on this number when making our own determination. (*An example is that the QAM marked recommendations that WSI chose not to implement as "100%" complete which could be erroneously interpreted to mean the recommendation was actually approved and implemented.*) Note that our assessment as depicted in Table 5.1 is independent of any % complete assigned by WSI.

  Additionally, the 100% complete status assigned by QAM to implemented recommendations did not include the Internal Audit manager's independent assessment of the recommendations. Thus, the Board has regularly been informed that recommendations were 100% complete when in fact a subsequent Internal Audit review could very likely over-turn this status. (See Recommendation 5.1)

- BDMP noted that Internal Audit had a significant backlog of recommendations submitted for review by the QAM that were awaiting Internal Audit review. During our onsite work, Internal Audit made a large effort to try to review many of these outstanding recommendations. However, it is unlikely that Internal Audit will be able to fulfill its oversight responsibilities until it is staffed by a qualified manager and supporting staff. (See Recommendation 5.1)

- BDMP observed that the QAM maintains an Access database to track recommendation status and generate reports. The QAM also maintains paper records (kept in binders) to document implementation activities and utilizes a tracking sheet to record senior management signoff for accountability.

  Control Sheets used by the QAM to track recommendations rarely included basic information such as history of actions and final disposition. While a custom database (using Microsoft Access) is used to document this information, the data is rarely included on the Control Sheet that is used for document senior management review and approval.

The use of a Control Sheet to document senior management awareness and approval of recommendation disposition is an appropriate method for tracking accountability. However, signed Control Sheets with little or no descriptive information casts doubt on management's awareness of what is being approved. (See Recommendation 5.2)

- BDMP noted during its review that the internal audit role was lacking a qualified manager and was being handled by a long-time staff-member who has since taken a new position within WSI. From interviews and direct observation, BDMP noted that Internal Audit has been unable to implement (or had the resources to implement) the internal audit plan as agreed and approved by the Board Audit committee. It appears from these observations that the Internal Audit function may be unable to fulfill its responsibilities to the Board and WSI stakeholders. (See Recommendation 2.2)

Conclusion

Regarding PE2006 Recommendations

BDMP evaluated 109 prior recommendations from PE2006. Table 5-1 provides an overview of the recommendation analysis results with totals across the top and then grouped by both Priority and Element. BDMP determined that 56% of the 109 PE2006 recommendations were "Fully Implemented" in that WSI management concurred with the recommendation and took action to implement the recommendation. 21% were partially implemented in that some action has been taken but further action is required. Finally, 23% were not implemented and includes those recommendations that WSI did not concur with and chose not to implement.

Appendix C provides assessment information for each of the 109 PE2006 recommendations and is grouped first by Priority and then Element within that priority.

Table 5-1 below presents the recommendation status grouped by both priority and element.

Table 5-1: Summary of 2006 Performance Evaluation Recommendation Status*

- ***Percentages are read across from left to right. E.g. – Element E1 had 73% of its 15 recommendations "Fully Implemented."***

	BDMP Assessment By Status							
	Fully implemented		Partially Implemented		Not Implemented		Grand Total	
Number of Recommendations	61		23		25		109	
% of Total	56%		21%		23%		100%	
Grouped By Priority								
High	28	*62%*	10	*22%*	7	*16%*	45	*100%*
Medium	21	*48%*	13	*30%*	10	*23%*	44	*100%*
Low	12	*60%*	0	*0%*	8	*40%*	20	*100%*
Grouped by Element								
E1: Performance Measurements	11	*73%*	2	*13%*	2	*13%*	15	*100%*
E2: Safety and Loss Prevention	7	*70%*	2	*20%*	1	*10%*	10	*100%*
E3: Information Technology	22	*63%*	7	*17%*	6	*20%*	35	*100%*
E4: WSI Board	5	*56%*	2	*22%*	2	*22%*	9	*100%*
E5: Fraud Unit		*0%*		*0%*	2	*100%*	2	*100%*
E6: Medical Services	8	*60%*	4	*20%*	3	*20%*	15	*100%*
E7: Policyholder Service Functions	8	*35%*	6	*26%*	9	*39%*	23	*100%*

Recommendations

During our review of prior recommendations, we observed the internal processes and procedures used by WSI staff to track and communicate recommendation status to senior management and the Board of Directors. The following recommendations address these processes and procedures.

Recommendation 5.1: Require that recommendations be classified as "100%" complete only after Internal Audit has completed an independent validation of actions and final disposition. (Medium)

We recommend that consultant recommendation implementation status only be categorized or reported as "100% Complete" after the Internal Audit Department has completed its own, independent review and validation of the final disposition. This will ensure the Board is given information that has been validated by an independent party that does not report to the operational chain of command.

WSI Response: CONCUR

WSI will present recommendations at 100% complete only after Internal Audit has conducted its own validation. The Quality Assurance department will continue to report on the estimated percent of work completed for each audit/evaluation.

Recommendation 5.2: Improve the design and use of the "Recommendation Control Sheet". (Low)

> We recommend WSI create a "final" Control Sheet that is printed (as a report) from the tracking database and includes the detailed information maintained in the database. Signed Control Sheets with this information should increase at least the perception of true awareness and accountability by senior management.

WSI Response: CONCUR

In April 2008, Quality Assurance created a report that is printed from the Access database and attached to each recommendation control sheet before obtaining the appropriate signatures upon completion. This report contains all the information from the tracking database relating to that recommendation, including all the documentation gathered supporting the work completed to implement the recommendation.

Element 6: Claims

Element Six required an in-depth review of various aspects of the WSI claims process, and encompassed a total of six distinct areas of evaluation:

1) Denied claims;

2) Claims involving Independent Medical Exams (IME's);

3) Appropriateness and effectiveness of disability guideline integration into the claims management process;

4) "Routine processes" that claims and benefits follow from beginning to end, and claims involving Permanent Partial Impairments (PPI's);

5) Claims regarding degenerative conditions; and

6) Changes in WSI's claims management philosophy between fiscal years 2004 and 2006/2007.

This section addresses each aspect of the evaluation in sequence.

Evaluation of Denied Claims

Objective

Review WSI's denied claims to determine the rationale behind the denials and explain any trends in denials from 2003-2007. Evaluate the appropriateness of denials based on state law, administrative code and WSI policies and procedures. Provide a comparison to other claims payers' denial rates/trends.

Key Activities

To conduct these evaluations, BDMP undertook the following activities:

- Conducted interviews with the following WSI staff:
  - Chief of Injury Services
  - Medical Services Director
  - Claims Director
  - Medical Director

- Provider Relations Manager
- Claim Supervisors (2)
- Claim Adjusters (6)
- Case Managers (2)
- Utilization Review Supervisor
- Return to Work Supervisor
- Quality Assurance Manager
- PPI Auditor
- Constituent Liaison

- Reviewed the North Dakota statute and rules pertaining to the claims handling process along with the WSI Claims Procedure Manual, and selected a random sample of WSI claims for evaluation.

- Obtained a data extract file from WSI technical staff listing all new claims from July 1, 2002 through December 31, 2007, as well as Microsoft Excel files used to track acceptance rates (CL0961 Acceptance Rates FYXX.xls). From these files, BDMP selected a total of 100 random claims that had been denied.

- Logged into the WSI claim and document management system to evaluate the selected claims for compliance with North Dakota state law, administrative code and WSI policies and procedures.

- Reviewed state forms, claim notes, medical reports/notes, formal correspondence as well as WSI attorney work product (where applicable).

- Entered evaluation results into web-based survey software for tabulation and summarization.

- Reviewed relevant published reports addressing various aspects of WSI's operations, including:

    - Historical WSI Operating Reports
    - Prior Performance Evaluation Reports
    - The Marsh Claims Process Review (3/4/2008)
    - The Connolly & Associates Report to the Board of Directors (3/5/2008)
    - The Independent Medical Examination Audit Report conducted by DA Dronen Consulting (2/1/2007).

- Conducted interviews with other monopolistic state funds and large workers' compensation claims payers.

Observations & Findings

Of the 100 denied claims reviewed by BDMP:

- 60 were from 2007 injuries, 40 were from 2006.
- Each initial claim denial decision reviewed appeared appropriate based on state law, administrative code and WSI policies.
- The sample included one claim that was incorrectly categorized as a denial and had not actually been denied.

Of the remaining 99 denied claims reviewed:

- Only five were from injured workers who requested a reconsideration of the denial decision.
- Four of the reconsiderations resulted in a reversal of the initial decision and an acceptance of the claim, whereas the initial decision of the fifth reconsideration was upheld and the claim was denied without further legal action.
- Only 1 of 100 denied claims evaluated resulted in a referral to the Office of Independent Review (OIR) and in that instance, the denial was upheld.

All reviewed denials appeared to follow the process outlined in the WSI Claims Procedure Manual, with the adjuster documenting the denial reason and issuing the required Notification of Decision (NOD) document. We noted:

- Standard claims handling processes also were followed for reconsiderations as documentation in the files confirmed that claim supervisors and in-house legal were engaged whenever injured workers submitted written requests for reconsiderations.

- Four denial reasons—No signed C1 form (C1 form is the Injured Workers signed First Report of Injury), Claim Comment (utilized when the decision to deny does not fit the categories already established and needs explanation noted in the claim notes with an event to the supervisor), No Medical Treatment (an incident that did not require medical treatment) and Uncooperative—accounted for 81% of all denials within the evaluated population of claims. Those same four reasons were also the top four reasons cited among all denials from 2006 to 2007 and accounted for more than 85% of all denials over that period, as illustrated in Table 6-1 below.

Table: 6-1: Percent of Initial Denials by Reason, FY2006-07

	% of Evaluated Denials	% of All Denials 2006-07
No Signed C1	28.0%	26.5%
Claim Comment/Active	24.0%	35.9%
No Medical Treatment	16.0%	12.5%
Uncooperative	13.0%	10.3%
Not Covered by WSI	9.0%	2.2%
Injury due to Alcohol/Drugs	4.0%	0.5%
No Medical Records	2.0%	2.8%
Treatment not by DMP	2.0%	1.8%
Claim Withdrawn	1.0%	4.0%
Not Timely Filed	1.0%	0.8%
All Other Reasons	0.0%	2.7%
Grand Total	**100.0%**	**100.0%**

- It should be noted that of the evaluated denials, 61% were for purely "administrative" reasons including:
    - No signed C1 form filed by the injured worker;
    - Failure to seek medical treatment;
    - Claim outside North Dakota's jurisdiction (not covered by WSI);
    - Alcohol/drug involvement;
    - Claim withdrawn or not filed within the required timeframe; and
    - Treatment not by DMP.

- An additional 13% of the denied claims were denied due to lack of cooperation (Uncooperative) where the adjuster had requested additional information or documentation from the injured worker to support the compensability determination but never received the additional documents or forms.

- Similarly, 2% of the claims were denied due to lack of medical records from the treating provider. Typically, claims that fell into these last two categories of denials were merely the result of following state law and WSI policies, and did not require any additional adjuster judgment or decision-making.

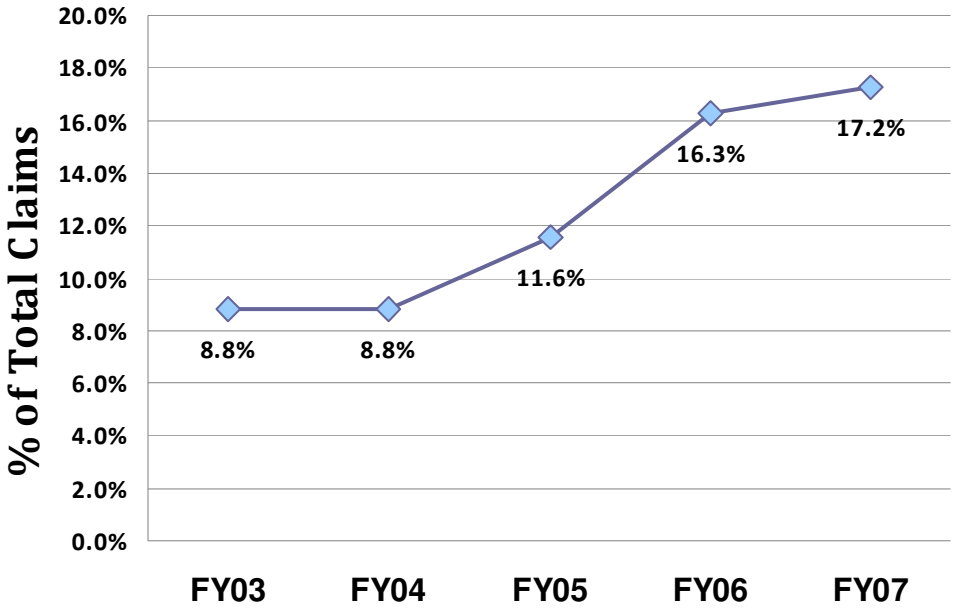
- The remaining evaluated denials were for reasons documented in claim comments, which did typically involve adjuster judgment or interpretation.

    - 20 of the 24 claims denied with "Claim Comment" as the reason were denied because the adjuster believed that the reported injury was not work-related or was an aggravation/trigger of a pre-existing condition.

    - Injured workers requested reconsiderations in writing on only 2 of the 24 "Claim Comment" denials, and only one of those reconsiderations resulted in a reversal of the initial denial.

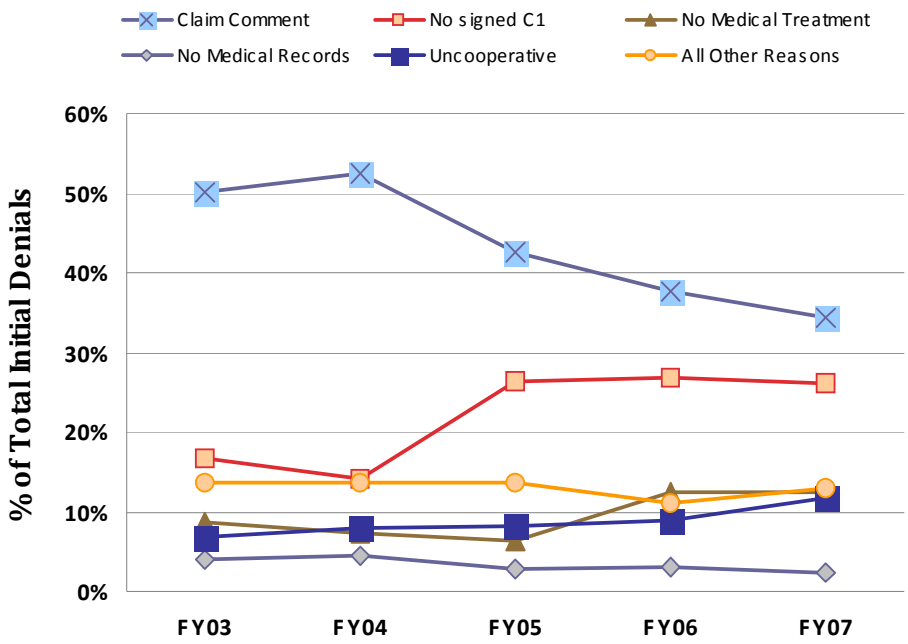
When the historical WSI data was analyzed, there was a notable increase in the percent of new claims denied after the initial adjuster investigation beginning in fiscal year 2005. The unadjusted denial rate had consistently run between 8.5% and 8.8% of all new claims in each fiscal year from 2000 to 2004, but as Figure 6-1 demonstrates, the rate began to climb dramatically in FY2005.

Figure 6-1: Unadjusted Percent of New Claims Denied at Initial Determination



By fiscal year 2007, the unadjusted denial rate had nearly doubled to 17.2%. However, more than 80% of all denials were due to just five reason codes as illustrated if Figure 6-2.

Figure 6-2: Percent of Total Initial Denials, FY2003-07



- While the percent of all denials due to "Claim Comment" reasons actually *decreased* from fiscal year 2005 to 2007, three denial reasons accounted for the majority of the overall increase in the denial rate:
    - 1) No signed C1;
    - 2) No medical treatment; and
    - 3) Uncooperative.

Interviews with WSI staff provided additional insight into the reasons behind the growth of denials due to these three reason codes.

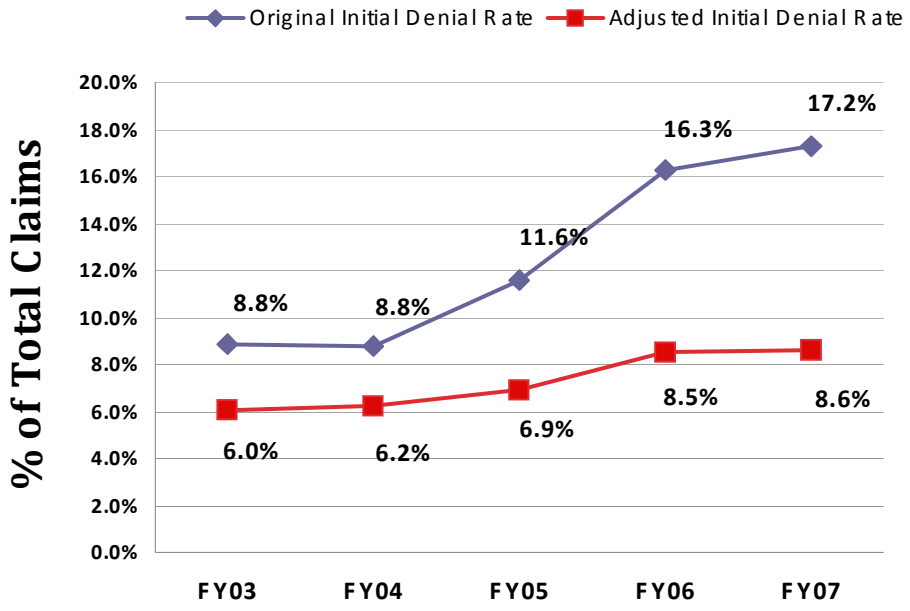
In fiscal year 2005, WSI initiated a new program designed to improve the timeliness of employers' submissions of first reports of injury forms. Prior to the new program, employers were automatically assessed a $250 fee for each new claim reported. The Early Claim Reporting Incentive program, instituted for all incidents after July 1, 2005, offered to waive the $250 fee assessment if the claim notice was received by WSI by midnight of the next WSI business day following the injury date. If WSI received notice of an incident within 2-14 calendar days of the injury date, employers would be assessed the "standard" $250 fee. However, if WSI did not receive notice of the claim until more than 14 calendar days from the date of injury, the fee assessment would increase to $350.

As a result of this new policy, employers began to report more incident-only events, many of which never resulted in an injured worker's submitting a corresponding C1 first report of injury form or even seeking any relevant medical treatment. At the end of the initial investigation period, adjusters would close these "claims" using one of the three reason codes outlined above. In most instances, these incidents would not have even been reported as claims prior to the fee policy change, but employers trying to avoid the $250 or $350 assessment began proactively reporting incidents which were ultimately closed as denied claims. It is common in the industry for employers to report these types of minor injuries as incidents but not count them in their "claim" count totals.

As a result of these unintended consequences of the fee policy change, WSI modified the denial rate calculation on quarterly Operating Reports to exclude denial reasons that could be associated with the change in employer behavior. This is called the "adjusted denial rate" as noted in the previous section. BDMP obtained a detailed spreadsheet of all of the WSI denials and reasons for denial and re-calculated the "adjusted rates" for the 2003-2007 timeframe. BDMP results matched the WSI adjusted denial rates in the operating report.

If the historical denial rate is adjusted to remove the denial reasons that could be attributed to the change in the fee assessment policy, it is clear that while the growth is not nearly as dramatic as the unadjusted numbers, the denial rate did indeed increase in FY2006 and FY2007. (Figure 6-3)

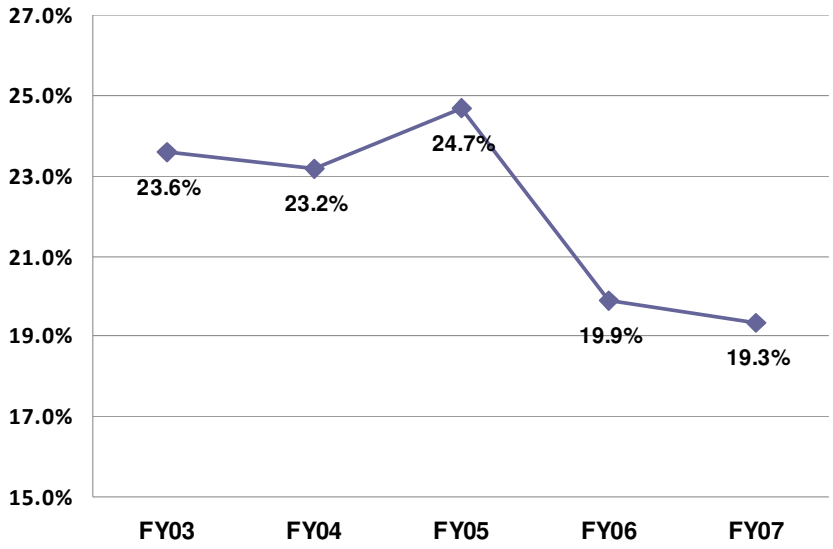
Figure 6-3: Adjusted Initial Denial Rate



As described by every claims staff member interviewed and as evidenced in the claim evaluations, the more intensive investigation prompted by the leadership change at WSI identified additional information on claims relating to prior injuries and pre-existing or degenerative conditions creating additional but appropriate denials according to the North Dakota statute.

Figure 6-4 shows that while the initial denial rate has increased since FY2004, the percent of initial denials that were ultimately reversed has actually decreased over the same time period.

Figure 6-4: Percent of Initial Denial Decisions Reversed

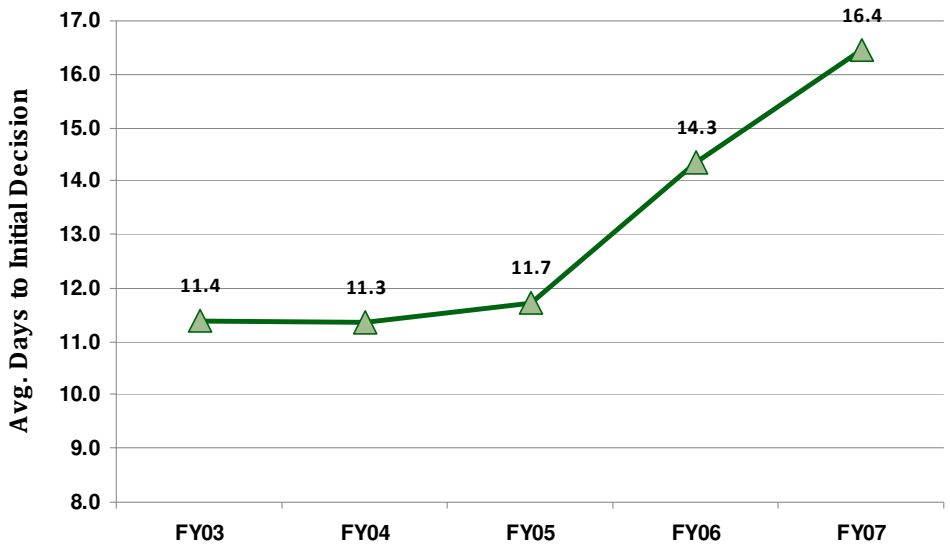


Again, based on the claim evaluations as well as the interviews conducted with staff in the Claims Department, it appears that the initial investigations regarding prior injuries/pre-existing and degenerative conditions became more rigorous 2005-2007 enabling better decision making in regards to acceptance/denial resulting in a smaller percentage of reversals.

In conjunction with analyzing the trends in claim denials, BDMP also reviewed WSI's trends in the timeliness of the initial adjudication decision (i.e. how long it took WSI staff to make the initial determination of whether to accept or deny a claim).

Figure 6-5 shows that from F72003 through FY2005, the average number of days required to make an initial compensability decision remained relatively constant between 11.3 and 11.7 days. As illustrated below, the average number of days began to rise in fiscal year 2006 and continued to rise in FY2007.

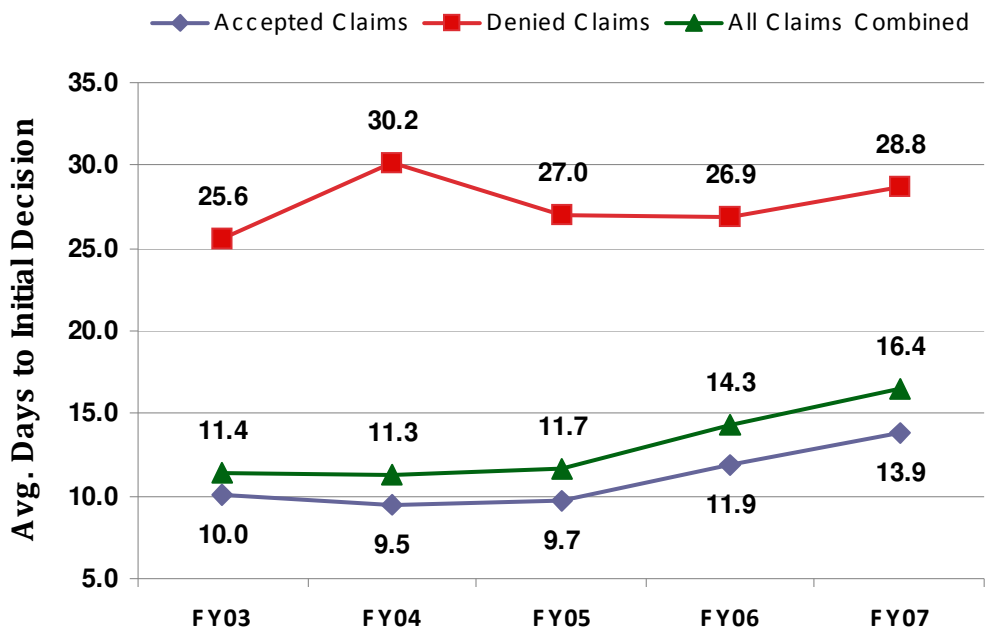
Figure 6-5: Average Days to Initial Compensability Decision, All Claims



Denied claims took nearly twice as long as accepted claims to reach an initial compensability decision, most likely because the standard WSI workflow requires that injured workers, employers and medical providers be given up to 30 days to supply additional information or missing forms before a claim can be administratively denied. In addition, a portion of the overall increase in average time to a compensability decision is clearly attributable to the increase in the number of denied claims in FY2006 and FY2007, and to those denied claims averaging twice as long as accepted claims to reach a compensability decision.

The average time to reach the compensability decision on claims initially denied did not increase as dramatically as that for claims initially accepted. (Figure 6-6)

Figure 6-6: Average Days to Initial Compensability Decision by Claim Type



For fiscal year 2007, the average time to the initial compensability decision on denied claims was 28.8 days, which was only 4% above the FY03-05 average of 27.6 days. By comparison, the average time to the initial compensability decision on claims that were accepted in FY2007 was 13.9 days, which was 42% higher than the FY03-05 average of 9.8 days. The increase in the average time required on accepted claims for FY2006 and FY2007 is consistent with feedback gathered during WSI interviews; during that timeframe, claims adjusters were being encouraged to be much more thorough in their initial investigations and to look for prior injuries or pre-existing conditions before accepting a claim as compensable. On average it appears that they were taking an additional 4-5 days to complete that additional investigation work.

The trend data suggests that even if the denial rates are adjusted to exclude claim denials that could be related to the administrative change in the $250 fee assessment policy, the overall claim denial rate did increase during FY2006 and FY2007. Likewise, the average time taken to reach an initial compensability decision clearly increased over the same time period. Our claim evaluation of 250 claims identified that adjusters were being very thorough in their initial claims investigations during that time period. Our analysis of 250 claims indicated that adjustments as a result of a change in management and a subsequent shift in philosophy – were encouraged during this time period to be very vigorous in conducting their initial investigations. This was born out during interviews with a variety of the claims staff.

Conclusions

BDMP's evaluations of denied claims uncovered no evidence of inappropriate claims handling processes or decisions inconsistent with state law or WSI claim policies. In our analysis of this element we concluded the following:

- When compared to other jurisdictions, the North Dakota statute is aggressive in empowering the claims payer to deny claims based on prior injuries or pre-existing conditions. None of the claims evaluated appeared to have been denied inappropriately based on what appears to BDMP to be a conservative state law, administrative code and supporting WSI claim policies as related to the definition of "compensability". (See Recommendation 6.5.)

- An analysis of historical WSI data revealed an increase in the percent of new claims denied after the initial adjuster's investigation, beginning in fiscal year 2005. However, the majority of this increase appeared to be related to a new program designed to improve the timeliness of first reports of injury rather than to any major shift in organizational philosophy.

- The amount of time it takes WSI to reach an initial adjudication decision increased to 16.4 days in FY2007, up from 11.4 days in FY2003. The management and philosophy change during the time period evaluated required adjusters to perform a more rigorous investigation as it related to prior injuries and pre-existing or degenerative conditions. In order to give the injured employee and the medical provider time to respond to the requested forms and letters, this investigation added time to the initial adjudication decision making.

- WSI staff consistently reported experiencing a change in philosophy surrounding the investigation of prior injuries, pre-existing or degenerative conditions during the 2006-2007 period of time. They described:

    - Being encouraged by management to become "more focused" on their investigations; and

    - Being more likely to be asked to request or review medical reports on these claims and/or to review them with the Medical Director before making a compensability decision.

  Although, WSI staff described how this change in philosophy changed their overall claims handling processes and delayed their initial adjudication decision, according to the interviews with claims personnel, it did *not* affect their ultimate decisions regarding claims compensability. However, BDMP noted in the claims evaluations that a more rigorous investigation clearly led to more information on previous injuries or pre-

existing or degenerative conditions with which to make a claim compensability decision. The denial trend supports the fact that the increased rigor of the initial investigations resulted in additional denials.

Evaluation of Independent Medical Exam (IME) Program

Objective

This component of Element Six required an evaluation of claims involving Independent Medical Exams (IME's), to determine the efficiency and efficacy of IME practices and to assess whether WSI was doing enough to encourage North Dakota physicians to participate in the IME program.

Observations & Findings

BDMP reviewed 50 random claims that had IMEs scheduled during the 2006/2007 calendar years.

- Forty-eight of the claims evaluated (96%) followed the appropriate IME referral process outlined in the WSI Claims Procedure Manual.

- The two instances that deviated from the standard referral process were appropriate IMEs however they did not have form C54—Prep Form Claims Assessment completed in a timely manner. This is an administrative form to be completed by the adjuster that instructs the claim technician to enter the IME into the Medical Events Window and generate a notice to the injured worker to attend the IME.

- The claim evaluations revealed that IMEs were utilized appropriately in the claims process and ultimately helped drive claims towards resolution 86% of the time. In other words, the claim adjuster was able to make decisions on the claim once they obtained an independent medical opinion. The remaining 14% of evaluated claims are still ongoing and have not yet been resolved. According to WSI, 0.5% of the claims are sent for IMEs. In every case BDMP examined, the adjuster chose an IME physician based on the specialty required to provide a thorough and accurate independent medical exam.

    - In many cases, rather than simply trying to match the specialty of the treating provider on record, the adjusters picked appropriate specialists based on the injured workers' injury types and the specific questions the adjusters had about the treatment/injury.

    - In every claim evaluated, the specialty of the IME physician was either the same as the treating physician or was a specialty better versed in the specific injury or treatment that was in question. The specialty of the IME physician was often

documented on the forms sent to the injured worker and on the report forwarded back to the adjuster.

- BDMP also noted that adjusters routinely worked to accommodate injured workers' schedules, assisted with travel planning and/or paid travel expenses when out-of-state trips were required for IMEs.

- Of the IME claims evaluated by BDMP with completed IME reports, 35% of the IME physicians agreed and 65% disagreed with the treating physician.

- Of the IME claims evaluated, only 18% were completed with North Dakota physicians, while 82% were scheduled with Minnesota physicians.

  - In multiple instances however, the Minnesota IME physicians traveled to North Dakota to complete the IME.

  - There was no significant difference between the IME results (agree/disagree with the treating physician) related to the location of the IME physician. 33% of the North Dakota IME physicians agreed with the treating physician compared to 35% of the Minnesota IME physicians.

  - The use of out-of-state IME physicians did not appear to significantly impact the efficiency of the claims process as IMEs performed in MN required a total of 46 days from the date the C54 Claims Assessment Worksheet was completed to the date the IME report was received. By comparison, IMEs scheduled in North Dakota required 41.4 days from the C54 to the final IME report.

During the interview phase, WSI staff charged with increasing the number of in-state IME providers outlined several significant initiatives that had been implemented in an effort to encourage North Dakota providers to participate in the IME program, but also noted that the fundamental challenge they face is the size of the North Dakota provider community. We noted:

- The most recent data from The Kaiser Family Foundation State Health Facts identifies a total of only 1,782 Non-Federal primary care physicians in North Dakota, compared to 17,295 in Minnesota and 973,524 nationally.[25]

- In addition, a significant number of the 1,782 physicians identified in North Dakota would not be appropriate for workers' compensation claims, as the Kaiser data suggests that 9% of all in state providers are Pediatricians and another 8% specialize in Obstetrics/Gynecology. If those specialties are removed from the North Dakota totals,

[25] Kaiser State Health Facts, http://www.statehealthfacts.org/profileind.jsp?ind=433&cat=8&rgn=36, (Jun 2008)

the entire universe of potential North Dakota workers' compensation primary care providers would appear to be less than 1,500 physicians.

- The most recently available data from the Bureau of Labor Statistics (BLS) summarized in Table 6-2 for relevant provider types, suggests that the North Dakota medical provider community is extremely small.

Table: 6-2: North Dakota Healthcare Practitioner & Technical Occupational Employment[26]

Occupation Code	Occupation Title	Employment
29-1011	Chiropractors	160
29-1062	Family and General Practitioners	370
29-1063	Internists	110
29-1067	Surgeons	120
29-1069	Physicians and Surgeons, All Other	350

- In a community with less than 1,500 primary care providers and only 120 surgeons, it is extremely difficult to find in-state providers who are willing to evaluate and potentially criticize the performance of their peers. Prices paid to providers for IMEs did not appear to be a deterrent as providers from MN were even willing to travel to North Dakota in multiple instances to perform examinations at the WSI rates.

Even with the paucity of physicians in North Dakota, WSI has worked to build relationships with providers and ultimately identify in-state providers for IMEs and PPI ratings:

- Added the position of WSI Provider Relations Manager in March 2005, focused solely on improving WSI's relationship with the ND medical provider community;
- Scheduled regional provider meetings in 2005 but then began regularly occurring one-on-one meetings with provider groups, their staff and appropriate association groups in Spring 2006;
- Distributed quarterly newsletter (MedProLink) to providers beginning August 2005;
- Formed a Medical Guidance Council in January 2006 that meets quarterly to discuss relevant issues, changes and suggestions;
- Implemented changes to the Provider Fee Schedule effective January 1st 2008, raising rates to levels higher than BC/BS reimbursement; and

[26] Bureau of Labor Statistics, *May 2007 State Occupational Employment and Wage Estimates*, http://www.bls.gov/oes/current/oes_nd.htm#b29-0000, (May 2007).

- Conducted an Impairment Rating training seminar for Medical Providers in November 2005.

BDMP also reviewed the February 2007 DA Dronen Consulting report which evaluated the Independent Medical Exam process in North Dakota, to determine if the results of that review could be helpful in the Performance Review. The most useful tactical recommendations from that report appear to have been implemented already or at least initiated by WSI staff as noted above. The report did not appear to offer any additional viable recommendations to address the fundamental environmental challenges inherent in the North Dakota IME situation.

The BDMP claim evaluations revealed that IMEs were utilized appropriately in the claims process and ultimately helped drive claims toward resolution. Due to the paucity of physicians with occupational specialties in North Dakota, many of the IMEs are sent out-of-state. The use of out-of-state IME physicians did not appear to significantly impact the efficiency of the claims process, as IMEs performed in MN required a total of 46 days from the date the C54 Claims Assessment Worksheet was completed to the date the IME report was received. By comparison, IMEs scheduled in North Dakota required 41.4 days from the C54 to the final IME report.

Conclusions

BDMP's review of 50 claims that had utilized IMEs during the evaluation period revealed that IMEs were utilized appropriately in the claims process and ultimately were a trigger that helped drive claims toward resolution 86% of the time (the remaining 14% of claims are still ongoing). We noted:

- WSI staff appear to be using IMEs appropriately and effectively. Referrals are being made to medical providers in appropriate clinical specialties; are being sent with specific lists of questions/issues to be addressed and are being processed in a very timely manner.

- The vast majority (96%) of the claims with IMEs that were evaluated followed the appropriate IME referral process outlined in the WSI Claims Procedure Manual. The remaining 4% (2 claims) were missing some minor administrative details noted as necessary in the Procedure Manual.

- A large portion of the IMEs are being completed by medical providers from outside North Dakota (82% of the claims evaluated). However, the use of out-of-state providers does not appear to be affecting the quality, timeliness or effectiveness of the IMEs themselves

- WSI has initiated reasonable efforts to increase the number of North Dakota medical providers willing to participate in their IME program, but the success of those programs

has been hampered by the relatively small number of appropriate providers in the state. WSI staff's perception is also that providers would be reluctant to judge or critically evaluate the work of their peers. (See Recommendation 6.3 for further ideas to potentially increase the providers for IMEs.)

Evaluation of Disability Guideline Integration

Objective

This component of Element Six required an evaluation of the appropriateness and effectiveness of disability guideline integration into the claims management process, including a comparison to disability guideline usage at other monopolistic state funds and large workers' compensation claims payers.

Observations & Findings

The nationally recognized Official Disability Guidelines (ODGs) developed by the Work Loss Data Institute were referenced consistently in interviews with all levels of WSI staff, including adjusters, supervisors, case managers, the Utilization Review manager, the Medical Director, and the Chief of Injury Services.

- Guidelines were mentioned as tools used for setting reserves, planning return-to-work targets, determining the appropriateness/necessity of medical treatment, building action plans/timelines for claim resolution and for benchmarking adjuster/unit performance.

- Only 7% of the claims in the general evaluation contained references to the ODG guidelines in the claim notes. Based on the claim reviews, it appeared that less experienced adjusters were documenting references to the guidelines in their claim or triage summaries while more tenured adjusters have become more familiar with the ODG guidelines and are not specifically documenting references to them in individual claims.

Over the past decade, the use of disability guidelines has grown dramatically in the workers' compensation industry, with "a total of 23 jurisdictions using national evidence-based guidelines (23 selecting ODG in whole or in part) and 21 considering national guidelines" according to ODG publisher, Work Loss Data Institute.

BDMP's experience and interviews with organizations that have implemented ODG protocols suggest that WSI has implemented the ODGs more comprehensively than the other monopolistic state funds and large insurance companies. Whereas other payers are more likely to utilize the ODG protocols for just medical management or utilization review, WSI staff at all

levels are more familiar with the guidelines and utilize them in the course of routine claims handling.

While their use at an individual claim level is excellent, WSI could make better use of the ODGs as a performance-benchmarking tool.

- WSI has not yet implemented higher-level reports or analyses that compare actual organizational performance against the evidence-based guidelines.
- Several WSI staff noted that this use of ODGs has been planned but has not yet been implemented.

Conclusion

After analysis of WSI's use of ODGs, BDMP determined the following:

WSI has not yet begun to evaluate actual organizational performance against the evidence-based disability duration guidelines. However, the use of the ODG at an individual claim level is notable. WSI's broad and thorough implementation of the ODG guidelines across multiple departments is more comprehensive than other monopolistic state funds and large insurance companies. As a result, this provides added value in that all members of the claims management team (medical staff, claims staff, supervisors, etc) are using the same benchmark and objective criteria to attempt to drive claims to resolution, providing added value to the process.

Evaluation of "Routine" Claims Processes & Permanent Partial Impairments (PPI)

Objective

This component of Element Six included an evaluation of the "routine processes that claims and benefits follow from beginning to end." The primary objective of this evaluation was to determine whether the claims handling process was efficient, timely and in accordance with state law, administrative code and WSI policies and procedures.

In addition, this evaluation included an analysis of whether the treatment and/or benefits provided to claimants were provided in a timely manner and whether the WSI processes placed any unnecessary or unreasonable burdens on injured workers.

Finally, this component of Element 6 required an evaluation specific to claims with PPI to determine whether those claims were processed in accordance with state laws/regulations and WSI policies and procedures.

Observations & Findings

The WSI staff interviews together with a review of the Claims Procedure Manual provided a detailed description of the standard WSI claims process from beginning to end, including the routine process for managing claims with PPI awards.

- The 100 claim evaluations completed for general claims processing (including 10 claims with PPI awards and 25 claims with degenerative condition diagnoses) followed the claims handling guidelines outlined by the interviews and the process specified in the claims manual very closely.

- Taken as a whole, the claims handling displayed in the evaluated files appeared proactive and timely.

- Most WSI adjusters displayed very dynamic management of their claims, in contrast to the reactive management style that often characterizes similar organizations facing similar rises in caseloads.

- WSI caseloads appear to remain very manageable and the staff interviews suggested that all of the available additional WSI resources (Nurse Case Managers, Return-to-Work specialists, the Medical Director, etc.) are well-publicized and leveraged appropriately to help resolve claims more efficiently.

Injury Management Model

The "Injury Management" model in particular provides an excellent example of industry best practices and teamwork. This model, which is currently in place with 2 claim units out of the 7 total claims units, essentially embeds the Medical Director as a key member into the claims team.

- By dedicating time each week to the case staffings and triage process for these units, the Medical Director dramatically improves the clinical expertise of the unit and helps speed the overall "velocity" of the claims handling process.

- Most of the claims staff with whom we spoke mentioned the increased speed and aggressiveness of the claim handling in this "Injury Management" unit. Decisions regarding treatment were made quickly and cooperatively rather than combatively.

- In this model, treatment does not have to go to the Utilization Review unit for pre-certification as the unit's nurse case manager has more authority to authorize treatment that they believe will help bring the claim to resolution. If the nurse case manager or adjuster has questions regarding proposed treatment, they can simply discuss the requests with the Medical Director during triage. This process is more representative of

what other claims payers in the industry are doing in that if there is a nurse case manager involved with a claim, and that nurse typically makes the utilization review decisions rather than forcing the treating provider to deal with a separate unit and process.

- The Injury Management model also helps adjusters identify potentially challenging claims before they escalate, set more appropriate goals and milestones for individual claims, and interact more effectively with treating providers. While many claims payers have attempted to inject more clinical expertise and/or injury management into their claims process, very few have succeeded as well as WSI. BDMP believes additional Injury Management rollout will result in improved outcomes. (See Recommendation 6.2.)

- During the interview process, staff identified the availability of the Medical Director as the primary obstacle prohibiting the rollout of this model to all of the WSI claims units. The WSI Medical Director currently serves less than half-time on the Utilization Review unit, reviewing the appropriateness of individual treatment requests for procedures such as physical therapy, CT/MRI scans, outpatient surgery, spinal injections, etc.

- According to UR management reports for calendar year 2007, the WSI utilization review unit actually only denied 7% of all treatment requests received. In fact, pre-certification requests for most types of care were approved more than 96% of the time, other than in several targeted areas such as chiropractic care, chronic pain evaluation, durable medical equipment, injections and palliative care. Given the tremendous value of the Injury Management model and the relatively low denial rates achieved via utilization review, the amount of the Medical Director's time dedicated to the utilization process may need to be re-evaluated in order to allow the rollout of the Injury Management model to the other 5 units. (See Recommendations 6.2 & 6.3.)

Claim Compensability

In terms of claim compensability, acceptance or denial decisions were well documented in 85% of the reviewed claims. The other 15% were simple, medical-only claims (e.g. foreign body in the eye, cuts, etc.) where there were few claim notes and the documentation was the NOD (Notice of Decision) in the imaged documents section of the file. Of the claims with more than 5 days of lost time, only 47% contained documentation indicating the 3-point contact was completed within 24 hours; however the contacts were eventually made and documented on 100% of wage loss claims.

- As noted above, there were compensability decision delays (30-50 days) in initial investigations when adjusters were researching pre-existing conditions or prior injuries. These delays were typically due to adjusters' waiting for requested medical reports related to the prior conditions.

- In the evaluated claims, there were instances where the injured worker was treated extensively prior to the adjuster's issuing a compensability decision. In several of these instances, the adjuster ultimately issued a denial. However, none of those claims resulted in the injured worker requesting a reconsideration in writing. Although the decisions on these claims were appropriate based on state law, administrative code and WSI policies and procedures, the research into potential pre-existing conditions did cause delays in the compensability decisions.

Permanent Partial Impairments

Claims with permanent impairments were managed appropriately.

- Of the 10 claims evaluated, four had permanent impairments of greater than 16% and an additional two had scheduled amputations that generated PPI payments and four had impairment ratings below 16% and therefore did not receive a PPI payment.

- All claims that had PPI awards were processed in a timely fashion. The average time from the date the PPI evaluation was completed to the date the PPI remittance was issued was 12.5 days. The average number of days from the AS35 order awarding permanent impairment to the date the PPI remittance was issued was only 5.5 days.

- Although a comparison to other jurisdictions of the 16% impairment rating needed in North Dakota to receive an award was not within scope of the biennial performance evaluation conducted by BDMP, it was noted that prior evaluations had suggested such a review. Since BDMP has recommended a review of other jurisdictional statutes for comparison of definitions of compensability, it is suggested that impairment ratings be added to the list of topics for the study group. (See Recommendation 6.5.)

Administrative Burdens Placed on Injured Workers

Administrative requirements placed on the injured worker in the process did not appear to differ significantly in North Dakota from what is commonplace throughout the rest of the industry.

- Requiring injured workers to return critical claim forms, attend medical appointments, adhere to work restrictions, return phone calls, etc. are a normal part of the workers' compensation claims process in most jurisdictions, although the North Dakota statute is somewhat more aggressive in terms of permitting the claims payer to deny benefits for injured worker non-compliance.

- WSI staff appeared to attempt to minimize administrative burdens for injured workers whenever possible, as evidenced in both the interviews and claim evaluations. Most administrative denials due to late or unsigned claim forms or lack of cooperation were

immediately reversed once the injured worker actually completed his or her responsibilities.

- In fact, the decision to deny one claim due to a positive drug test was reversed by the adjuster and accepted as soon as their investigation revealed that the injury was not related to the drug use. In similar circumstances, many claims payers would have placed the burden on the injured worker to prove that their drug use was not the cause of their injury and forced them to appeal the initial denial.

Vocational Rehabilitation

Unlike many other states, the Vocational Rehabilitation Program in North Dakota, as described in the WSI staff interviews, is extremely "injured worker-friendly" and very generous in both process and benefits. The Return to Work Supervisor shared that "this is the most 'emotional' program and one that requires a great deal of communication."

- BDMP learned that the cases going through Vocational Rehabilitation are generally the "toughest claims" since many of them are in industries and/or geographic locations where there is little opportunity for light duty or alternative employment. They often have to relocate injured employees to more populated areas in order for them to obtain employment.

- These employees go through a vocational assessment and a transferrable skills analysis, and often need upgrading to at least a GED. Employees who are unable to obtain employment that's provides a wage within a certain percent of their previous earnings are eligible for retraining. The 2005 law gave the injured worker two years to complete retraining as well as flexibility around the income test, i.e. even if they fail the income test they can still be recommended for retraining if they qualify.

- By comparison, in the state of Washington an injured worker who cannot return to his previous employment must accept any job available to him, no matter how menial and even if the wage is significantly lower than his injury wage.

While WSI staff consistently displayed a clear understanding of the needs of injured workers, the adjusters and supervisors interviewed by BDMP struggled to articulate how their performance was evaluated.

- Adjusters almost uniformly said that their primary goal was "to get injured workers the medical care they needed and then help them return to work as quickly as possible."

- Adjusters were unsure, however, how many active claims they currently were managing, how many of their claims were medical only versus time loss, or how the performance of their claim unit compared to others within WSI.

Conclusions

The 100 claim evaluations completed for general claims processing (including 10 claims with PPI awards and 25 claims with degenerative condition diagnoses) followed the claims handling guidelines outlined by the interviews and the process specified in the claims manual. We noted:

- The Injury Management Model being piloted by several of the claims teams delivers true "industry best practice" performance. However, constraints on the WSI Medical Director's time imposed by the Utilization Review unit have limited attempts to expand this innovative approach to all claim teams. Reviews of the relatively unimpressive Utilization Review results would appear to suggest that WSI would achieve better overall outcomes by investing more of the Medical Director's time in the Injury Management Model. (See Recommendation 6.2.)

- Claim compensability decisions were generally very well documented yet there were often delays in reaching the initial decision, based on the thoroughness of the research being conducted into pre-existing conditions or prior injuries(in order to address compensability as defined by state statute and procedural requirements as addressed by WSI Policies and Procedures.)

- Claims with Permanent Partial Impairments were managed appropriately according to state regulations and WSI operating guidelines. PPI award decisions appeared to be made in an objective and consistent manner. Once an award was approved, payments were processed very quickly. Since the 16% threshold for PPI awards seems rather high to BDMP and has been mentioned as high by other performance evaluations, it seems that review of other jurisdictional impairment rating percentages may be appropriate. (See Recommendation 6.5.)

- The administrative burdens placed on the injured worker did not differ significantly from the requirements placed by other jurisdictions. However, the North Dakota statute is somewhat more aggressive than most jurisdictions in permitting the claims payer to deny benefits in cases of injured worker non-compliance. In most instances reviewed, WSI staff appeared to work consciously to minimize administrative burdens on injured workers.

- The Vocational Rehabilitation benefit in North Dakota could be considered more "worker-friendly" than many comparable states and appears to be utilized appropriately by injured workers.

- While overall claims handling performance was clearly above average, WSI staff at multiple levels throughout the organization struggled to articulate their performance goals or how their individual performance was measured.

Evaluation of Claims with Degenerative Conditions

Objective

This component of Element Six entailed evaluating WSI's decisions regarding claims with degenerative conditions to determine whether they reflect industry norms.

Observations & Findings

BDMP identified a total of 72 claims from fiscal years 2006 and 2007 that had degenerative diseases/conditions according to ICD-9 diagnosis codes submitted by treating providers on medical bills for the relevant injured workers. Of those 72 claims with degenerative conditions, a random sample of 25 was selected for evaluation purposes. We found:

- The claims evaluated for this section showed consistent efforts by adjusters to identify and understand prior medical history.

- Rather than relying upon the First Report of Injury notation from the Injured Worker on whether or not he/she had a prior injury or pre-existing condition, 84% of the degenerative disease claims evaluated contained file documentation suggesting that claim history and/or index bureau services were searched for potential prior claims, indicating that adjusters were thoroughly investigating claims before making compensability decisions.

- Adjusters sent the C96a (Prior Injury Questionnaire) to the injured worker for completion on 44% of the claims with degenerative conditions and requested prior medical records via the FL304 form from medical providers on 56% of the evaluated claims, again indicating that the investigations on these claims were rigorous.

- Largely as a result of these efforts, adjusters documented prior injuries/pre-existing conditions in 56% of the claims identified as having degenerative conditions. On 31% of these claims with prior injuries or pre-existing conditions adjusters (using the FL332 form) communicated in writing to treating providers in an effort to determine if prior conditions were significant and if employment substantially accelerated or worsened an underlying condition.

- Ultimately, adjusters identified 18% of the claims with degenerative conditions as aggravations of prior injuries.

As a whole, the degenerative condition claims demonstrated a significantly higher level of documented involvement of the claims supervisors and/or the WSI Medical Director when compared against the population of general claims evaluated.

- Sixty percent (60%) of the claims with degenerative conditions contained documentation suggesting the claim was staffed with a supervisor versus only 15% of the claims in the general evaluation population.

- Similarly, 38% of the claims with degenerative conditions had documented referrals to and/or staffings with the WSI Medical Director before an initial compensability decision was made versus only 8% of the claims in the general evaluation population.

At the end of the initial claim investigation process, a total of 44% of the claims with degenerative conditions were accepted as compensable workers' compensation claims, while nearly double that figure (83%) of the general population of WSI claims were accepted after the initial investigation.

All of the degenerative disease claims evaluated did contain documentation of the acceptance/denial rationale and all of those decisions appeared appropriate per state law, administrative code and WSI policies. Adjusters documented their search for prior injuries or pre-existing conditions on every evaluated degenerative claim, and the WSI Medical Director also reviewed nearly 40% of the claims before an initial compensability decision was made.

While all claims followed the required investigation and documentation process, there was some variability in how the compensability decisions were applied to the evaluated degenerative condition claims.

- In some instances, when the adjuster's investigation revealed a pre-existing or degenerative condition, the adjuster would accept compensability for just the medical treatment relating to the new, specific injury, while explicitly excluding any treatment required by the underlying pre-existing condition.

    - For example, in one claim in which an injured worker slipped on the ice and bruised their knee, subsequent diagnostic imaging revealed a pre-existing degenerative knee condition that was likely to require a knee replacement surgery.

    - The adjuster accepted compensability for the knee contusion as work-related and agreed to pay for the associated medical treatment (ice packs and limited physical therapy), but explicitly denied compensability for a future knee replacement.

- In other instances, once it was determined that a prior injury or a pre-existing, degenerative condition existed, the entire claim was denied due to lack of clear evidence that the injury was work related.

- Results in each of these instances still appeared to conform to state law, administrative code and WSI policies, as the language of the existing North Dakota statute and the complexity of determining causality in cases with prior injuries or pre-existing degenerative conditions leave significant room for interpretation up to the individual adjusters.

These results point to the challenges inherent in determining compensability on claims with pre-existing conditions, particularly those that relate to degenerative conditions. While many jurisdictions have begun to try to address the issue of the compensability of claims with pre-existing injuries and/or conditions related to the aging process, few have gone as far as the North Dakota statute, which explicitly excludes as non-compensable:

> *Injuries attributable to a pre-existing injury, disease, or other condition, including when the employment acts as a trigger to produce symptoms in the pre-existing injury, disease, or other condition unless the employment substantially accelerates its progression or substantially worsens its severity.*[27]

This language, together with the additional explicit exclusion of "ordinary diseases of life to which the general public outside of employment is exposed,"[28] in the North Dakota Workers' Compensation Century Code, provides WSI adjusters with a clear ability to deny claims that they determine are either a trigger/aggravation of a prior injury or are due to pre-existing/degenerative conditions. However, the WSI Claims Procedure Manual does require the adjuster to clearly document the rationale for their denial and include any evidence, such as medical records, suggesting that an injury was related to a pre-existing or degenerative condition. (See Recommendations 6.1 & 6.5.)

Comparison to Others on Degenerative Disease Claims

BDMP interviewed a variety of industry experts and staff at other monopolistic funds/large payers in an attempt to determine whether WSI's treatment of claims with degenerative conditions was consistent with current best practices in workers' compensation.

- The Vice President at the Property Casualty Insurers Association (PCIA) reported that the handling of degenerative condition claims is dictated by the jurisdictional statutes in place within each state and that many states' statutes support the acceptance of the injured employee "the way the employer found him/her." If a work injury magnified the

[27] N.D.C.C. § 65-01-02(10)(b)(7)
[28] N.D.C.C. § 65-01-02(10)(b)(1)

symptoms of an underlying condition, the employer is typically responsible for the entire medical/disability claim. The fight for limiting a payer's liability or apportionment then typically only occurs if/when the issue of permanent disability is raised, not during the initial claim compensability investigation.

- The Vice President of Risk Management and Workers' Compensation for Safeway, Inc. and an active participant in workers' compensation reform initiatives across multiple jurisdictions, noted that "there are wide variances in how states define compensability." He used the example of a work-related orthopedic injury that exacerbates an underlying debilitating chronic disease such as AIDS or diabetes. In California and many other states, medical care associated with the underlying pre-existing condition would typically be paid for as the intent of the workers' compensation system would be to return the injured employee to work and pre-injury status. He agreed with PCIA that in most instances "the medical care would be covered, but any permanency would be apportioned."

  He went on to point out that there are typically also statutory differences in the language used to define compensable injuries as either arising out of employment (AOE) or in the course of employment (COE). In most cases, statutes that utilize "AOE" language focus primarily on whether an injury occurred while an employee was at a location relevant to their employment while "COE" statutes tend to focus on whether the activity being performed by the employee at the time of the injury was related to their job rather than just a routine "activity of daily living." For example, if an injured worker strained their back while lifting a box of parts on a loading dock, that would be considered a compensable injury in both types of jurisdictions. If that employee suffered the same back strain while bending over to pick up a pencil off the floor in the hallway, it might be considered a compensable injury in an AOE state, but would likely be deemed an activity of daily living in a COE state and judged non-compensable. The North Dakota statute actually includes both requirements in its definition of compensability:

  > *"Compensable injury" means an injury by accident arising out of and in the course of hazardous employment, which must be established by medical evidence supported by objective medical findings.*[29]

- In the monopolistic state of Washington, even if there was a pre-existing/degenerative condition, the state fund is typically forced to accept full liability for the whole claim so long as the injury occurred at work.

  - According to the Deputy Director of the Washington Department of Labor & Industry, there are very few instances where the fund would not accept a claim

[29] N.D.C.C. § 65-01-02(10)

that was determined to occur while the employee was working; even a broken tooth while chewing is an accepted claim for a salaried employee.

- In Washington, the standard claims process is to check for priors/pre-existing conditions generally only if subrogation is involved as the Deputy Director noted, "since the statute in the state of Washington is relatively liberal relative to pre-existing conditions, the Department does not take much action on pre-existing conditions and generally just accepts the claims." He previously led the Illinois Workers Compensation Commission and he shared that the Illinois statute is very similar to the Washington statute, as it relates to pre-existing/degenerative condition claims and claims payers do not typically challenge at intake.

- The Louisiana Workers' Compensation State Fund (LWCC) told BDMP, *". . . the way we handle it [claims with pre-existing conditions] is to work with the physician to determine at what point they are treating the pre-existing condition versus the aggravating injury. Those lines are often not clear. The bottom line is if they [workers] are injured we would probably even pay for the pre-existing situation until it is established that the physician is only treating the back problem that existed prior to the injury."*

  - Louisiana also has a Second Injury Fund, established to encourage employers to hire workers with pre-existing conditions. Each claims payer in the state is assessed an amount that is contributed to the fund.

  - If an injured worker's injury is exacerbated or complicated due to a pre-existing condition, the workers' compensation payer pays for any necessary medical treatment but can apply to the Fund for reimbursement of care that was attributable to the pre-existing condition. This process is designed to help ensure that employers do not discriminate against potential workers with pre-existing conditions in the hiring process and that if an injury does occur the injured worker receives the appropriate medical care they require.

- A study commissioned in 2000 by the Workers' Compensation Division of the Oregon Department of Consumer and Business Services in which researchers conducted a comprehensive analysis of the statutory compensability standards for workers' compensation injuries found that:

  - The actual statutory language is often critical to a clear understanding of compensability standards. The danger in not looking at the precise language is that different standards may be incorrectly lumped together and variations may

not be understood. In addition, states sometimes have different standards depending on the particular physical or mental condition involved.[30]

- In addition, their review found that some states "have specifically eliminated compensability for the natural aging process, conditions caused by daily living, the ordinary diseases of life, or degenerative conditions."[31]

All of the industry experts and other claims payers contacted by BDMP regarding the question of pre-existing injuries or degenerative conditions commented that decisions regarding pre-existing/degenerative conditions are dictated by the state statute and the interpretation of that statute by the courts within that state. (See Recommendation 6.5.)They made a point of saying that due to the different nature of both the statutes and the interpretations of each statute, there is currently no industry-wide norm for dealing with degenerative condition claims.

Conclusions

During the interview phase of BDMP's evaluation, WSI staff consistently noted a change in claims philosophy that occurred during FY2006-2007 in which adjusters were encouraged to investigate all new claims for prior injuries or pre-existing conditions much more thoroughly. In addition:

- BDMP's claim evaluations suggest that there was additional scrutiny applied to new claims in this regard, but at the same time, BDMP did not find any inappropriate denials given the definition of "compensability" in the state law, administrative code and WSI policies. The claims evaluation and trending analysis did however suggest that there was a push to have adjusters follow the statute regarding the investigation into the compensability of pre-existing or degenerative conditions more rigorously than had previously been the norm.

- While all claims followed the required investigation and documentation process, there was some variability in how the compensability decisions were applied to claims with pre-existing and/or degenerative conditions. (See Recommendation 6.1.)

The way compensability decisions are made at other state funds and large payers regarding pre-existing or degenerative conditions is driven almost entirely by the language of the statute(s) in which they administer claims. The North Dakota statute is conservative and it provides adjusters with direction to deny claims with pre-existing injuries and/or degenerative conditions than most other jurisdictions. (See Recommendation 6.5.)

[30] Edward M. Welch, Workers' Compensation Center Michigan State University, *Oregon Major Contributing Cause Study,* http://www.cbs.state.or.us/wcd/administration/finalmcc.pdf, (Oct, 2000), p. 106
[31] Welch, *Oregon Major Contributing Cause Study,* p. 109

Evaluation of WSI Claim Philosophy

Objective

This component of Element Six directed that BDMP determine whether there had been a change in the organization's claims management philosophy between fiscal year 2004 and fiscal year 2007. We also were asked to provide a comparison of WSI's claims management "philosophies" to those of other monopolistic funds and large workers' compensation payers.

Observations & Findings

Each WSI employee BDMP interviewed was asked about changes in the claims handling philosophy and the timeliness of adjudicating a claim. We found:

- Employees consistently commented on the shift in management focus to a more aggressive and in- depth search for prior injuries or pre-existing/degenerative conditions, which could possibly reduce WSI liability for the injury.

- According to the interviews and the data included in this report, this change in philosophy did lengthen the initial investigation process with new claims and helped drive a 25% increase in the adjusted denial rate from fiscal year 2005-fiscal year 2007. The Chief of Injury Services said, "We were losing focus on the test of compensability. We need to go back to our basics and make the call based on our training and get the claim accepted or denied without all the extensive analysis," and reported that the extent of the analysis spent on priors/pre-existing conditions was keeping claims pending for longer periods of time.

Claim evaluations suggest that, despite these philosophical changes, overall claims handling remained extremely strong during the period and there was no evidence that claims were being denied inappropriately.

Investigation of prior injuries and pre-existing conditions including obtaining and reviewing all previous relevant medical records is "best practice" in Workers' Compensation claims handling, although many state statutes support apportionment only as it relates to permanency. Given the unusual but explicit direction given by the North Dakota statute to deny compensability based on a work-related injury acting as a trigger for a prior injury or pre-existing condition, the denials reviewed by BDMP appeared reasonable.

Conclusions

As noted elsewhere, WSI staff consistently referenced experiencing a change in claims philosophy during FY2006-2007. They reported that adjusters were more frequently encouraged to investigate all new claims for prior injuries or pre-existing conditions much more thoroughly. Of note were the following:

- The philosophical change within WSI appears to have been real. However, this shift appears to have been motivated by a desire to follow the language of the statute more closely and to leverage the power it provides the claims organization to reduce WSI's liability for a specific subset of claims with prior injuries or pre-existing conditions. The North Dakota statute is conservative in its definition of "compensability" as compared to other jurisdictions. (See Recommendation 6.5.)

- There was evidence of some variability in adjuster judgment in relation to the compensability of those claims, yet all decisions appeared to be well within the scope of state law, administrative code and WSI procedures. (See Recommendation 6.1.)

Recommendations

Recommendation 6.1: Revise the WSI Claim Procedure Manual to standardize "best practices" and train claims adjusters on new practices. (High)

> WSI should clarify claims handling processes and procedures regarding the acceptance or denial of claims with prior injuries and/or pre-existing/degenerative conditions and train or re-train all existing claims adjusters on these new practices.

WSI Response: CONCUR
Adjudicating claims involving prior injuries, diseases and conditions has, and remains a challenge within North Dakota. Establishing training on this issue is extremely important to ensure consistency. Claims training has been conducted and is scheduled on an ongoing basis. Updating the claims procedure manual is an ongoing process as well.

Recommendation 6.2: Implement the Injury Management pilot program across all 7 claim units by ensuring better utilization of the WSI Medical Director. (High)

WSI Response: CONCUR
Currently, the Medical Director, Pharmacy Benefit Director, Return to Work Manager, and Claims Director are involved in the Triage for Units 2, 6, and 7. Plans are being developed for implementation of Injury Management into the remaining units. Additionally, WSI has hired three new nurse case managers to imbed within each unit.

Recommendation 6.3: Decrease the amount of time the WSI Medical Director dedicates to the Utilization Review unit. (High)

Suggestions on how this may be accomplished include:

- Limiting the procedures/treatments that require pre-authorization to those where utilization review appears to be having an impact (e.g. chiropractic care, chronic pain evaluation, etc); and,

- Utilizing external physician advisor services, rather than the Medical Director, to assist the utilization review process.

WSI Response: CONCUR

Effectively using the Medical Director's time is a challenge and requires balance. WSI has begun altering his assignments with the intention of increasing availability. Since Jan. 05 through June 06 the average monthly UR requests completed by the medical director was 303. From Jan. 07 through May 08, the average monthly UR requests completed by the medical director were 122. This was a reduction of 60%. Long term goal is to reduce the number by approximately another 20 to 30%.

We have also trained and started having the UR Nurses conduct some of the reviews that were previously completed by the Medical Director. Expansion of allowing Medical Case Managers to conduct Utilization Review on the claims they are assigned is planned. Initial training has been completed.

On July 1, 2008, a pilot program was established that CT scans done in the first 30 days from the date of injury will no longer require pre-authorization from WSI.

Recommendation 6.4: Investigate additional sources for North Dakota IME providers and peer review. (Low)

This may be accomplished by publishing a request for information to determine the ability of the new national Peer Review/IME firms to provide Peer Review/IME services utilizing providers in North Dakota.

WSI Response: CONCUR

The Service Requisition for IME services has been signed and approved accordingly by WSI staff. This requisition is the first step in the process of developing a Request for Proposal (rather than a Request for Information) for IME services. Plans are to include many of the current IME needs but to also take into account the proposed recommendations from the 2007 IME audit.

Recommendation 6.5: Enhance WSI's knowledge of industry best practices through staff attendance at appropriate industry conferences. (Medium)

Regular attendance at workers' compensation industry trade events is an important means for WSI management and staff to stay informed on industry benchmark standards, new processes and procedures, current and future trends, and general industry dynamics. Examples of these learning opportunities include:

- Workers' Compensation Research Institute Conference
- National Workers' Compensation & Disability Conference
- Annual National Workers' Compensation & Occupational Medicine Conference

WSI Response: CONCUR

North Dakota is a monopolistic insurer. In order to continue performance at the highest levels, WSI recognizes the need for continual training of staff at all levels. Due to WSI's monopolistic nature, these training opportunities often occur outside of the state of North Dakota. This increases the expense of training due to travel costs but resources have been, and will continue to be focused on this area. Historically staff has participated in various AASCIF workshops, NCCI conferences, and the National Workers' Compensation & Disability Conference and will continue to do so.

Recommendation 6.6: Review the North Dakota Statute in relation to other jurisdictions. (High)

In our work, BDMP observed that the North Dakota statute is more conservative than most other jurisdictions as it relates to prior injuries, pre-existing or degenerative conditions, triggers and aggravations and impairment rating percentages. BDMP recommends that a study group formed of all the stakeholder groups be brought together to review how other jurisdictions' statutes handle these important Workers' Compensation issues. Suggested sources of information for this study group include:

- Edward M. Welch, Workers' Compensation Center Michigan State University, *Oregon Major Contributing Cause Study,* http://www.cbs.state.or.us/wcd/administration/finalmcc.pdf, (Oct, 2000)
- Clayton, Ann, *Inventory of Workers' Compensation Laws - Beta Version, March 2007,* Workers' Compensation Research Institute, Cambridge, MA : Only available to members of WCRI and/or IAIABC.

WSI Response: CONCUR

WSI will undertake a study of the adequacy of the current law in these areas. Currently, this issue is being reviewed with WSI by the North Dakota Industry Business & Labor interim committee. Whether any legislative changes will occur as a result of insights gained is not known but WSI will continue to monitor.

BDMP Concluding Remarks

While it is beneficial that the WSI and IB&L committee consider this, we re-iterate the importance and benefit to the State of North Dakota that a multi-perspective stakeholder group be assembled to specifically study this issue.

Element 7: Evaluation of the Change in Financial Condition from FY 1997 through FY 2007

Objective

Element seven entailed evaluating the change in the financial condition of WSI from fiscal year 1997 through fiscal year 2007 and developing a list of the factors that contributed to the change in WSI's financial condition over that period of time. We were also asked to assign a "weight" or "value" to each of the factors, to provide an idea of the significance of the contribution from each. Factors to be considered included:

- Change in the structure of the organization from reporting to the Governor to reporting to a board of directors;
- Change in economic conditions in the state and in the nation;
- Legislative changes (including all that affected payments to injured workers and employer contributions);
- Changes or trends relating to total employer contribution revenue to the agency; and,
- Changes involving the actuarial analysis of the fund.

This evaluation resulted in a specific ranking of the factors which contributed to the change in WSI's financial condition over the ten year period of time.

Key Activities

To conduct this analysis, BDMP undertook the following activities:

- Obtained copies of the audited financial statements for each of the years ending June 30, 1997 through June 30, 2007 and prepared a summary of the audited financial statements for this 10 year period.
- Reviewed the history of legislative and actuarial changes with Glenn Evans from Pacific Actuarial Consultants (PAC). PAC performed the actuarial analysis on an annual basis during the period under review.
- Analyzed a summary provided by management of the number of individuals covered by WSI during the period of July 1, 2002 through June 30, 2007.

- Analyzed the financial position as of each year-end and the statement of changes in financial position for each of the years ending June 30, 1997 through June 30, 2007.

Conclusion

BDMP's analysis revealed that, the fund balance increased from a deficit of approximately $10,692,000 as of June 30, 1996 to a surplus of approximately $466,835,000 as of June 30, 2007, which represents an approximate increase of $477,527,000. Our analysis of the factors contributing to the increase in the net assets (in descending ranking) during the 10 year period ending June 30, 2007 is as follows:

Investment Return in Excess of Assumed Rate of Return

The primary explanation for the increase in the fund balance is due to the performance of the investments during the 10 year period ending June 30, 2007. One of the key assumptions involved with the rate setting process is the estimate of the investment return that will be available to pay losses as they come due in the future. If the investment income falls short of what is assumed, a shortfall may exist in the future. If the investment income exceeds the assumed rate of return, a surplus may be generated. Based on the independent review performed by Casualty Actuarial Consultants, Inc. (CACI) for the 2005/2006 and 2006/2007 rate setting reports, a conservative interest rate of 2.5% was utilized, which made it less likely that a future shortfall would exist. The assumed rate of return has an inverse relationship to the actuarially determined contribution rate required to fund the claims of the workers' compensation program.

Based on the investment return analysis performed below, the average rate of return was approximately 7.2% during the 10 year period ending June 30, 2007. The fact that the investment return outperformed the assumed rate of return resulted in an overall surplus from the total employer contribution revenue to the agency. Based on the information included in Table 7.5, the estimated financial impact on the contribution revenue to the agency resulting from the actual rate of return exceeding the assumed rate of return is approximately $450 million.

Changes or Trends Relating to Total Employer Contribution Revenue to the Agency

One of the key assumptions in the employer rate setting is the discount rate utilized to estimate the present value of the cash flow required to pay future estimated claims. WSI also utilizes a discounted estimate of the ultimate claims costs when establishing the year-end reserves for the financial statements. WSI elected to utilize the following discount rates to determine the employer rates and the year-end reserves recorded on the financial statements during the years ending June 30, 1997 through June 30, 2007:

Table 7.1: Schedule of Discount Rates

Policy Year Ended June 30,	Discount Rate for Employer Rate Setting	Discount Rate for Year-End Reserves
1997	6.0%	6.0%
1998	3.5%	6.0%
1999	3.5%	6.0%
2000	2.5%	6.0%
2001	2.5%	6.0%
2002	2.5%	6.0%
2003	2.0%	6.0%
2004	2.0%	6.0%
2005	2.5%	5.0%
2006	2.5%	5.0%
2007	2.5%	5.0%

Changes in the discount rate use for employer rate setting have an inverse relationship with the amount of the employer contribution revenue to WSI. For example, assuming no other changes, the decrease in the discount rate from 6% for the June 30, 1997 policy year to the 3.5% rate used for the rate setting for the June 30, 1998 would result in higher employer contributions. It would be difficult to isolate the dollar impact that the above changes had on the employer contributions received by WSI.

BDMP performed a calculation of the net earned premium per covered worker compared to the claims awards per covered worker. Based on information provided by management and the audited financial statements, we noted the following:

Table 7.2: Analysis of net earned premium and claims awards per covered worker[32]

Policy Year Ended June 30,	Number of Covered Workers	Net Earned Premiums per Covered Worker	Claims Awards per Covered Worker	Premium Surplus (Deficit)
1997	280,969	$ 447.91	$ 285.72	$ 162.19
1998	287,801	423.42	378.97	44.45
1999	292,868	383.94	333.29	50.65
2000	296,663	333.96	204.38	129.58
2001	299,714	289.31	290.09	(0.78)
2002	301,913	303.29	182.77	120.52
2003	301,777	293.56	494.19	(200.63)
2004	304,287	318.06	345.50	(27.44)
2005	311,200	333.11	329.00	4.11
2006	318,240	284.05	260.72	23.33
2007[33]	326,100	392.88[33]	396.67	(3.79)

As of June 30, 1996, WSI had a deficit of approximately $10.7 million. As a result, WSI recognized the need to increase employer rates in order to recover from this net deficit position and to begin building a fund surplus. Based on Table 7.2, the net premiums earned per covered worker (based on the rates established for the year ending June 30, 1997) produced a positive result when compared to the claim awards per covered worker. We noted a trend where in a year following a premium surplus per covered worker, as identified above, the net earned premiums per covered worker decreased. We also noted that in a year following a premium deficit per covered worker, as identified above, the net earned premiums per covered worker increased. This is a reasonable trend to expect in the rate setting process for a workers' compensation program.

The only exception to this trend is the increase in the net earned premiums per covered worker for the year ending June 30, 2007. The claims awards per covered worker also increased during the year ending June 30, 2007. If the premiums had not been increased, the premium deficit would have been larger.

Change in Discount Rate for the Unpaid Loss Liability

During fiscal year 2005, WSI evaluated the appropriateness of discounting its unpaid loss liability at 6%. The discount rate is a major assumption in order to report this liability at its

[32] Information obtained from audited financial statements.
[33] Prior to June 30th, 2007, the dividends paid to policy holders were included in net earned premiums.

present value. Given the condition of the economy and markets, the Board of Directors of WSI decreased the discount rate assumption from 6% to 5%. This change resulted in a $55.1 million decrease in the fund's net assets during the year ending June 30, 2005.

Impact of Other Revenue Sources

During the 10 year period ending June 30, 2007, WSI also received operating revenue from its policyholders for various penalties and interest amounting to approximately $21,890,000. During the year ending June 30, 2004, WSI began generating rental income from a new facility that was constructed and partially occupied by WSI. The rental income generated from this facility during the years ending June 30, 2004 through June 30, 2007 amounted to approximately $2,514,000.

Net Change in the Undiscounted Estimated Incurred Claims and Expenses

The audited financial statements include the required Loss Development Information, which is supplementary information required by the Governmental Accounting Standards Board.

Line 5 of the Loss Development Information shows how each policy years' estimated incurred losses increased or decreased at the end of each successive year. This annual re-estimation is the result of new information received regarding unknown claims, re-evaluation of existing information on known claims, as well as the emergence of new claims not previously known.

Line 6 of the Loss Development Information compares the latest re-estimated incurred losses amount to the amount originally established at the end of the policy year and shows whether the latest estimate of claims cost is greater or less than the original. If the latest claims cost is less than the original, the fund surplus would increase in the year of the change in the estimate. If the latest claims costs are greater than the original, the fund surplus would decrease in the year of the change in estimate.

Based on our review of the Loss Development Information included in the audited financial statements, the overall estimated incurred claims and expenses have decreased by a cumulative amount of approximately $18.7 million.

The historical claims activity included on the Loss Development Information indicates that WSI has conservatively estimated the year-end reserves at the end of the policy year, which over time, will have a positive impact on the fund surplus as the policy year matures and the estimated losses are reduced.

It is difficult to attribute the change in estimated incurred claims to single factors nor is it easily expressed as a result of specific legislative changes, changes in the underlying estimates related to the outstanding case load as of the date of the reserve calculation, judicial decisions, internal changes in practices and procedures over time, or other activities. The year-end reserve setting

process is based on actuarial calculations that represent a significant estimate in the financial statements of workers' compensation organization, and is subject to change over time. It is not unusual for an organization to have significant changes in the estimated incurred claims as the policy years mature. If the estimated losses at the end of a policy year were less than the final loss incurred on the policy year, there is a risk that employer contributions and investment income would not be sufficient to cover the claims costs and administrative expenses of the organization.

Based on the work performed for Element Four, we understand that there were significant changes in the workers' compensation legislation in 1995. Our discussions with WSI's actuary, revealed that it took several years to identify and determine what impact those changes were going to have on the reserve and rate setting process. Once the impact of the 1995 workers' compensation reform was better understood, there was a resulting decrease in the estimated undiscounted incurred claims. The analysis of the change in the estimated undiscounted claims in table 7.6 for the policy years ending June 30, 1996 through June 30, 1999 is consistent with WSI's actuary's representations to BDMP.

Change in Economic Conditions in the State and in the Nation

Based on our evaluation, we understand that the economy in the State of North Dakota has experienced growth over the past 10 years. Information provided by WSI's management revealed that, the average number of covered employees increased from 280,969 during the year ending June 30, 1997 to 326,100 during the year ending June 30, 2007, which represents an increase of approximately 16%.

Our interview with the actuary from PAC confirmed that the number of individuals covered by WSI has increased at a faster rate than the salary growth of existing employees. Also with the boom in the energy industry in North Dakota, there has been more payroll growth in the higher rate classes than the lower rate classes.

Change in the Structure from Reporting to Governor to reporting to Board of Directors

BDMP considered the impact of the change in the structure of the organization from reporting to the Governor to reporting to a board of directors. Based on the work we performed, we did not identify any direct or indirect correlation between the change in the reporting structure and the increase in the fund surplus during the 10 year period ending June 30, 2007.

Financial Data Used to reach our conclusions:

The following tables summarize the financial data used to reach our conclusions.

Table 7.3: Summary of the balance sheets of WSI as of the years ending June 30, 1997 through 2007

	As of June 30, (in Thousands)										
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Cash and cash equivalents	$ 1,296	$ 1,786	$ 328	$ 190	$ 854	$ 750	$ 427	$ 1,748	$ 1,996	$ 1,383	$ 1,677
Investments	546,953	683,252	770,510	892,284	918,156	899,170	974,987	1,071,222	1,160,077	1,192,399	1,291,853
Invested securities collateral	135,491	143,605	169,226	215,994	161,207	115,394	130,202	275,839	325,422	326,132	252,580
Premiums receivable, net	32,590	27,160	24,605	35,025	21,872	17,510	13,312	17,205	21,290	16,489	40,399
Retrospective receivable	-	-	-	-	-	-	-	-	-	-	195
Other accounts receivable, net	1,062	766	1,071	1,903	2,139	2,429	5,564	1,683	849	516	465
Interest receivable	4,038	4,708	5,499	7,926	7,402	8,108	7,225	7,652	8,764	8,925	8,774
Prepaid expenses	13	7	-	470	470	325	56	24	5	75	33
Total current assets	721,443	861,284	971,239	1,153,792	1,112,100	1,043,686	1,131,773	1,375,373	1,518,403	1,545,919	1,595,976
Restrospective policy premium	-	-	-	-	-	-	-	-	-	-	2,033
Equipment, net	2,159	1,708	1,707	1,299	2,119	4,922	12,239	12,106	11,939	11,513	11,161
Total assets	$ 723,602	$ 862,992	$ 972,946	$ 1,155,091	$ 1,114,219	$ 1,048,608	$ 1,144,012	$ 1,387,479	$ 1,530,342	$ 1,557,432	$ 1,609,170
Accounts payable	$ 896	$ 819	$ 1,165	$ 2,595	$ 2,335	$ 3,949	$ 2,695	$ 2,082	$ 3,083	$ 3,109	$ 2,222
Compensated absences payable	317	417	412	410	46	53	504	549	596	627	707
Other current liabilities	42	100	67	42	44	71	56	91	41	61	170
Retrospective rate adjustment	-	1,114	-	430	1,013	-	-	-	-	-	-
Dividend payable	-	-	-	10,379	10,044	-	-	-	-	47,821	56,909
Securities lending collateral	135,491	143,605	169,226	215,994	161,207	115,394	130,202	275,839	325,422	326,132	252,580
Deferred revenue	51,832	48,919	42,102	49,299	45,487	41,861	42,970	45,970	54,545	39,277	63,024
Claims reserves	434,900	476,700	508,800	499,700	75,000	75,000	80,000	70,000	70,000	70,000	93,000
Total current liabilities	623,478	671,674	721,772	778,849	295,176	236,328	256,427	394,531	453,687	487,027	468,612
Compensated absenses	-	-	-	-	411	473	89	97	105	111	124
Dividends payable	-	-	-	-	-	-	-	-	-	24,743	35,699
Other long-term liabilities	-	-	-	-	-	34	-	-	-	-	-
Claims reserves	-	-	-	-	440,000	425,800	497,500	534,100	610,400	616,800	637,900
Total liabilities	623,478	671,674	721,772	778,849	735,587	662,635	754,016	928,728	1,064,192	1,128,681	1,142,335
Fund surplus, end of year	100,124	191,318	251,174	376,242	378,632	385,973	389,996	458,751	469,150	428,751	466,835
Total liabilities and fund surplus	$ 723,602	$ 862,992	$ 972,946	$ 1,155,091	$ 1,114,219	$ 1,048,608	$ 1,144,012	$ 1,387,479	$ 1,533,342	$ 1,557,432	$ 1,609,170

Table 7.4: Summary of the Statements of Revenues, Expenses and Changes in Fund Net Assets for the years ending June 30, 1997 through June 30, 2007

(in thousands)
For the Year Ended June 30,

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Operating revenue	$ 130,825	$ 126,517	$ 116,275	$ 102,301	$ 90,182	$ 94,167	$ 90,747	$ 99,712	$ 106,195	$ 94,383	$ 130,586
Claim awards	(80,278)	(109,067)	(97,610)	(60,632)	(86,944)	(55,182)	(149,136)	(105,132)	(102,385)	(82,973)	(129,355)
Operating expenses	(12,332)	(14,103)	(11,991)	(12,570)	(14,262)	(16,578)	(17,919)	(17,183)	(17,906)	(18,666)	(16,302)
Income (loss) from operations	38,215	3,347	6,674	29,099	(11,024)	22,407	(76,308)	(22,603)	(14,096)	(7,256)	(15,071)
Investment and other income	72,601	87,847	53,182	95,969	13,414	(15,066)	80,331	91,358	79,595	39,422	121,020
Increase in surplus before change in discount rate and dividend	110,816	91,194	59,856	125,068	2,390	7,341	4,023	68,755	65,499	32,166	105,949
Change in discount rate	-	-	-	-	-	-	-	-	(55,100)	-	-
Increase in surplus before dividend	110,816	91,194	59,856	125,068	2,390	7,341	4,023	68,755	10,399	32,166	105,949
Dividend expense	-	-	-	-	-	-	-	-	-	-	(67,865)
Increase (decrease) in fund surplus	110,816	91,194	59,856	125,068	2,390	7,341	4,023	68,755	10,399	32,166	38,084
Fund surplus, beginning of year	(10,692)	100,124	191,318	251,174	376,242	378,632	385,973	389,996	458,751	469,150	501,316
Prior period adjustment [1]											(72,565)
Restated surplus, beginning of year	(10,692)	100,124	191,318	251,174	376,242	378,632	385,973	389,996	458,751	469,150	428,751
Fund surplus, end of year	$ 100,124	$ 191,318	$ 251,174	$ 376,242	$ 378,632	$ 385,973	$ 389,996	$ 458,751	$ 469,150	$ 501,316	$ 539,400

[1] Per Note 2 to the audited financial statements as of and for the year ending June 30, 2007, a "prior period adjustment was made to reflect WSI's current accounting practice for dividends declared by WSI's Board of Directors. Accounting principles generally accepted in the United States of America requires that dividends declared but unpaid are to be recorded as an expense in the current period with a corresponding liability on the balance sheet. Prior to fiscal year 2007 dividends declared by WSI's Board of Directors were expensed in subsequent periods as they were applied to employers billing statements. As a result, a prior period adjustment of $72,564,531 has been made to reduce the fiscal year 2007 beginning Net Assets to properly reflect dividend expense pertaining to prior years."

Table 7.5: Analysis of the investment return during each of the years ending June 30, 1997 through June 30, 2007 (in thousands)

Year Ended June 30,	Average Investment Balance	Investment Income	Actual Rate of Return	Assumed Rate of Return	Assumed Investment Income	Investment Income Surplus (Deficit)
1997	$ 480,881	$ 72,627	15.1%	6.0%	$ 28,853	$ 43,774
1998	615,103	87,870	14.3%	3.5%	21,529	66,341
1999	726,881	53,229	7.3%	3.5%	25,441	27,788
2000	831,397	95,977	11.5%	2.5%	20,785	75,192
2001	905,220	13,518	1.5%	2.5%	22,631	(9,113)
2002	908,663	(15,066)	-1.7%	2.5%	22,717	(37,783)
2003	937,079	80,383	8.6%	2.0%	18,742	61,641
2004	1,023,105	91,390	8.9%	2.0%	20,462	70,928
2005	1,115,650	79,602	7.1%	2.5%	27,891	51,711
2006	1,176,238	39,421	3.4%	2.5%	29,406	10,015
2007	1,242,126	121,020	9.7%	2.5%	31,053	89,967
	$ 9,962,343	$ 719,971	7.2%			$ 450,461

Table 7.6: Change in the undiscounted estimated incurred claims and expenses since the end of each of the policy years ending June 30, 1997 through June 30, 2007

	(In Thousands)				
Policy Year Ended June 30,	Starting Estimated Loss Date	Estimated Loss at Beginning of Analysis	Ending Estimated Loss Date	Estimated Loss at End of Analysis	(Decrease) Increase in Estimated Loss
1988	6/30/1996	$ 86,368	6/30/1997	$ 85,122	$ (1,246)
1989	6/30/1996	92,851	6/30/1998	107,165	14,314
1990	6/30/1996	105,907	6/30/1999	120,390	14,483
1991	6/30/1996	95,876	6/30/2000	104,768	8,892
1992	6/30/1996	91,640	6/30/2001	95,929	4,289
1993	6/30/1996	87,884	6/30/2002	86,902	(982)
1994	6/30/1996	90,663	6/30/2003	97,459	6,796
1995	6/30/1996	96,838	6/30/2004	87,411	(9,427)
1996	6/30/1996	94,160	6/30/2005	70,999	(23,161)
1997	6/30/1997	84,551	6/30/2006	72,107	(12,444)
1998	6/30/1998	89,020	6/30/2007	70,340	(18,680)
1999	6/30/1999	92,130	6/30/2007	79,959	(12,171)
2000	6/30/2000	80,505	6/30/2007	88,825	8,320
2001	6/30/2001	82,905	6/30/2007	84,864	1,959
2002	6/30/2002	80,567	6/30/2007	89,752	9,185
2003	6/30/2003	92,605	6/30/2007	90,270	(2,335)
2004	6/30/2004	102,960	6/30/2007	100,363	(2,597)
2005	6/30/2005	110,710	6/30/2007	99,532	(11,178)
2006	6/30/2006	105,264	6/30/2007	112,278	7,014
2007	6/30/2007	120,109	6/30/2007	120,109	-
					$ (18,969)

Recommendations

No recommendations were made for Element 7.

Element 8: Policyholder Services

Objective

Element Eight encompasses five specific components:

1. An evaluation of the employer rates and employee classifications to determine if they are appropriate and consistently applied;

2. A determination of whether the audit plan utilized by the Policyholder Services Division is risk based and appropriate;

3. A review of the overall structure and note those industries having their own classifications and determine if it would be more fair and appropriate to combine them with other classifications;

4. A determination of whether the premium rebates to employers is an indication that premium billings are too high or whether they are reasonable; and,

5. A comparison of WSI's premium rebates to other "monopolistic" stats and large insurance companies.

This section addresses each objective in sequence described above.

Evaluation of Employer Rates and Employee Classifications

Objective

Evaluate WSI employer rates and employee classifications and determine if they were appropriate and consistently applied. We also were asked to determine if premiums were calculated in accordance with established guidelines and calculated consistently and fairly.

Key Activities and Findings

To conduct this analysis, BDMP undertook the following activities:

1. Selected a sample of premium billings to test the employer rates and employee classifications compared to legislatively approved rate sheets. The process to perform this test was as follows:

- We reviewed a listing provided by management of net premiums billed by policyholders for the contract years ending June 30, 2006 and June 30, 2007.

- We obtained rate sheets for the policy years ending June 30, 2006 and June 30, 2007.

- We selected 30 premiums billed for the contract year ending June 30, 2006 and 30 premiums billed for the contract year ending June 30, 2007 for testing.

- For each selected policyholder, we agreed the net premium billed on the listing provided by management to the supporting invoice noting no exceptions.

- We agreed the employer rate for each applicable employee classification to the applicable rate sheet noting no exceptions.

2. We selected five policyholders from the June 30, 2006 contract year and five policyholders from the June 30, 2007 contract year in order to test the calculation of the policyholders' experience rating. We noted no exceptions.

3. We worked with a listing of policyholder billings provided by management that included gross premiums, experience adjustments, and net billings for each of the contract years ending June 30, 2007 and 2006. We then selected three policyholders with significant positive experience adjustments and three policyholders with significant negative experience adjustments. We reviewed the underlying calculations for these six policyholders' experience adjustments for both contract years noting no exceptions.

4. We obtained a listing of Board members who served during 2006 and 2007. This list included each member's employer. Premium information for each member's employer for contract years ending June 30, 2007 and 2006 was extracted from the gross-to-net premiums file provided by management. BDMP tested the underlying documentation for any experience adjustment in excess of an absolute value of $100,000 noting no exceptions.

5. We selected a sample of premium billings which had an adjustment of any type for the contract years ending June 30, 2007 and 2006, in order to test the appropriateness of the adjustment. We noted no exceptions.

6. We obtained a listing of NAICS codes for WSI's policyholders from management. BDMP utilized the NAICS listing, combined with the net premium information obtained for test #1, to select five NAICS codes for testing. Once the NAICS codes were selected, the policyholders with the two highest net premiums (before discounts and dividends) from each selected NAICS code were selected for testing.

BDMP compared the employee rate classifications for two selected policyholders for each NAICS classification to identify any unusual differences in employee rate classifications. For the policy years ending June 30, 2007 and 2006, we did not identify any unusual inconsistencies in the employee rate classifications for the 10 policyholders tested.

7. We compared the rate classifications utilized for the policy year ending June 30, 2007, utilizing the same policyholders utilized under test #6, to the rate classifications to the policy year ending June 30, 2006 noting no unusual changes.

Conclusion

Based on the testing performed, as described in our key activities and findings above, we did not identify any inconsistently applied employer rates or employee classifications.

It was noted during the review of the policies and procedures related to the experience calculation that there are three individuals that are able to manually change the experience rate applied to policyholder's premiums. Based on discussions with the Director of Policyholder Services, the only time that changes are made is when policies are consolidated or subrogated. Per discussion with the Director of Policyholder Services, changes are occasionally performed on paper by staff members and brought to the Director of Policyholder Services for change in the system. At this point, he will review the change to verify reasonableness. However, that review process is not documented. Also noted through discussion and review of the system, these changes are tracked by who is performing the change and the system has the ability to generate a listing of the policies changed, that listing is not being reviewed. (See Recommendation 8.1)

Policyholder Services Division Audit Plan

Objective

Determine if the audit plan utilized by the Policyholder Services division is risk based and appropriate.

Key Activities

To conduct this analysis, BDMP undertook the following activities:

1. Conducted interviews with WSI management to gain an understanding of the process utilized by WSI to determine which policyholders are selected for premium audits.

2. Read recommendation 7.95 included in the 2006 Performance Evaluation conducted in 2006 that WSI establish a structure that documents the rotational plan for the premium audits. We also read WSI's response to this recommendation.

3. Obtained a listing of the premium audits conducted by the Policyholder Services (PHS) division through April 30, 2008.

4. Obtained the current audit plan in place for the premium audits by district assigned by WSI.

Observations & Findings

In order to monitor the status of the audit plan, WSI has segregated its policyholders into five geographic districts. A download from the PICS system was performed for each district that included net premium for the contract year ending June 30, 2007 in an excel format. Each excel file also included the date of the last audit performed by WSI. Five tabs were then added to each spreadsheet which represents the audit plan for each of the next five years. The district databases were then sorted in descending order based on net premiums.

All premiums in excess of $100,000 were added to each of the upcoming five years.

The number of policyholders in the $25,000 to $100,000 range was divided by three to determine how many of these audits should be done in a year. Once the number of audits required was determined, the policyholders were allocated to the first three audit plan years based on descending net premiums. The premium audits planned for year one were then added to the audit plan for year four. The premium audits planned for year two were then added to the audit plan for year five.

For the policyholders in the $5,000 to $25,000 range, the number of policyholders was divided by five to determine the number of audits to be conducted in a year. Once the number of audits required per year was determined, the policyholders were allocated to the five year audit plan based on descending net premiums.

We noted that the current audit plan does not include a planned response and follow-up for premium audits for policyholders with premiums in the $5,000 to $100,000 range that result in exceptions outside of a pre-determined tolerable range. Under the current audit plan, policyholders with premiums in excess of $100,000 are audited each year, therefore there is an appropriate response and follow-up for the policyholders in excess of $100,000. (See Recommendation 8.2)

Based on the information provided by the PHS division, Table 8-1 presents the number of premium audits conducted under the new audit plan through April 30, 2008.

Table 8-1: Results of audits conducted from July 1, 2007 through April 30, 2008

Premium Size	Audit Plan	Conducted Audits	Net Premiums	Credit Adjustments	Debit Adjustments
> $100,000	230	126	$40,655,869	$ (185,765)	$ 243,411
$25,000 to $100,000	285	243	12,809,405	(91,635)	102,970
$ 5,000 to $ 25,000	605	475	6,466,726	(38,224)	126,497
	1,120	**844**		**$ (315,624)**	**$ 472,878**

The spreadsheet used to track the status of the premium audit also includes the hours to complete the audit and the drive time associated with the premium audits. Based on the spreadsheet, it appears that the average time to complete the premium audit, including drive time, ranges from 6.6 hours to 8.8 hours. Based on the average time to complete the premium audits and the number of audits planned each year, the total number of hours associated with the premium audits is approximately 8,100 hours.

Conclusion

Prior to June 2007, WSI utilized a random methodology to select claims to be tested. Based on our review of the net premiums billed for the contract year ending June 30, 2007, approximately 15,500 policyholders had individual premiums less than $5,000 that aggregated to approximately $17,360,000. During the contract year ending June 30, 2007, WSI had approximately 19,400 policyholders with aggregate premiums of approximately $149,570,000. Therefore, the policyholders with individual premiums represented approximately 80% of the policyholders and approximately 12% of the total net premiums. As a result, the likelihood that the random methodology would select policyholders with premiums in excess of $5,000 was limited. In addition, WSI's ability to have a sample size sufficient enough to produce an effective audit approach using the random methodology was limited due to the fact that there is not sufficient staff in the PHS division to conduct the premium audits. (See Recommendation 8.3)

In June 2007, the premium audit policy selection model was modified to respond to the Octagon report and to better utilize the limited personnel resources in the PHS division. Table 8-2 presents the premium audit plan established in response to the Octagon report (based on 2006 policy year):

Table 8-2: 2006 Premium Audit Plan

Frequency	Premium Size	# of Accounts	Hours per Audit	Total Hours Estimated	Estimated Hours per Year
Annually	> $100,000	169	16.50	2,789	2,789
3-Year	$25,000 to $100,000	619	7.75	4,797	1,599
5-Year	$ 5,000 to $ 25,000	2,394	6.50	15,561	3,112
Totals		3,182		23,147	7,500

As noted above, the audit policy does not include policyholders with premiums under $5,000 in the audit plan.

Based on the above audit plan, we concluded that WSI is appropriately focusing its premium audit efforts on the significant policyholders where potential audit adjustments could yield a more significant result.

Consideration of Overall Rate Structure

Objective

In this component of Element Eight, BDMP considered the following items related to the overall rate structure:

- Any industries that have their own classifications and determined if it would be more fair and appropriate to combine them with other classifications.
- Whether the number of classifications within WSI's system is reasonable considering the size and nature of the state's workforce in comparison to other monopolistic states and large insurance companies (regarded as industry leaders).
- If rates were calculated based on reasonable "industry standards" logic and process (compared to other monopolistic states and large insurance companies (regarded as industry leaders) that specialize in providing workers compensation insurance).
- WSI's rate information benchmarked against information gathered from other entities.

Key Activities

Casualty Actuarial Consultants, Inc. (CACI), a member of the BDMP project team, performed the analysis for this component of Element Eight. CACI undertook the following activities:

1. Reviewed the 2005 – 2006 and 2006 to 2007 rate analyses prepared by WSI's actuary on their behalf;

2. Considered the actuarial analysis conducted during the period of our assessment in light of standard actuarial methodology; and,

3. Compared the number of classifications and rates to those used by similar entities to WSI.

CACI's analysis findings are presented on the following pages.

Findings, Analysis, and Conclusions:

Actuarial Review of Manual Rates

CACI considered the 2005-06 and 2006-07 rate analyses prepared by WSI's actuary on their behalf. The rate analyses reviewed WSI's prior loss history as the basis for establishing an overall rate indication, as well as manual rates by class code for the 2005-06 and 2006-07 periods. CACI's conclusions below focus mainly on the 2006-07 rate analysis since the two reports are largely similar. A description of changes made from the 2005-06 report to the 2006-07 report is noted where applicable.

Overall Rate Appropriateness

When evaluating the appropriateness of workers compensation rates, actuaries are to be guided by the "Statement of Principles Regarding Property and Casualty Insurance Ratemaking", adopted by the Casualty Actuarial Society (CAS) in May, 1988. According to Principle 4 of this document:

> *"A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer."*

Thus, in determining the appropriateness of the rates utilized by WSI, CACI considered that the rates are reasonable and not excessive, inadequate, or unfairly discriminatory. Based on CACI's review, the rates established in the 2005-06 and 2006-07 rate analyses meet these four criteria.

In its analyses, WSI'S actuary included reasonable provisions for administrative expenses and for loss and loss adjustment expenses (for claims both less than and greater than $1,000,000). Administrative expenses are supplied by WSI and reflect the actual administrative expenses incurred by WSI.

The loss and loss adjustment expense provisions for losses limited to $1,000,000 are based on the experience of the five most recently completed fiscal-accident years, and are discounted to

their present value using a discount rate of 2.5%. In the 2006-07 report, the provision for losses in excess of $1,000,000 is selected to be 7.5% of manual premium. This represents an increase of 2.5% in this provision from the 2005-06 report. The 2005-06 report noted that the 5.0% utilized was based on recent excess insurance quotations received by WSI. This justification was dropped in the 2006-07 report and no reason was given for the selected 7.5% provision. (See Recommendation 8.5-a)

Including a provision for losses in excess of $1,000,000 is a necessary and appropriate action for WSI. (See Recommendation 8.5-b) In other jurisdictions the size of WSI, the provision would most likely be based on an analysis of claims larger than $1,000,000. This analysis would be performed by the jurisdiction's actuary or by an insurance company providing an excess of loss coverage quotation, neither of which would be readily available for comparison. The reasonableness of the provision utilized in WSI's case depends upon the unique claims history of WSI and the potential for losses in North Dakota to exceed $1,000,000.

WSI'S actuary also includes a provision to account for the overall average experience modification factor of 0.960. Since the premium after application of the experience modifiers is approximately 4.0% less than prior to the modifiers, the loss ratio is adjusted upward to maintain premium adequacy. This is an appropriate and necessary adjustment; however, it is not clear where this factor comes from or how it is calculated. (See Recommendation 8.5-a)

An adjustment that is new in the 2006-07 analysis is the backlog in medical payments provision. WSI's actuary adds a 1.5% provision to the premium need without identifying specifically what this covers or justifying this additional provision. WSI's actuary also removes the provision for law changes as there were no applicable changes to incorporate.

Finally, the risk management and safety incentive program offset of 0.950 included in the 2005-06 analysis has been changed to 1.000 for 2006-07. The impact of this change is that there is no longer a 5.0% provision in the rates to cover these expenses. WSI's actuary has indicated that these expenses will now be paid from surplus rather than as a component of premium. (See Recommendation 8.5-c) Presumably, this was a decision made by the WSI Board of Directors.

It is important to note that the changes from the 2005-06 report to the 2006-07 report outlined above result in somewhat offsetting effects. Adding in the back log in medical payments provision and increasing the losses in excess of $1,000,000 provision add approximately 4% to the indicated loss and expense ratio, while removing the risk management and safety incentive program provision decreases the ratio by about 5%.

WSI's actuary calculate a 0.9% decrease in the premium rates, but the WSI Board of Directors decided to keep the premium rates at the same level for the period 2006-07. (See Recommendation 8.5-e) Although WSI did not adopt WSI's actuary's recommended rate change, the selected rate change (0.0%) would certainly fall within a range of reasonable rate

indications. Therefore, CACI concluded, the rate indication calculated by WSI's actuary, as well as the overall rate change adopted by WSI, meet the criteria outlined above and are appropriate.

Rates by Class Code

After selecting the overall rate change, it is time to apply that rate change to each class code. WSI's actuary has done this in two steps. First, the class codes are combined into 14 groups to determine a group rate change. The indicated group rate change is then spread to the class codes in that group so that the overall group rate change and WSI's selected overall rate change are achieved.

The procedure of first combining the class codes into groups of like classes is utilized since there are some class codes with very little payroll in the review period. By combining class codes into groups, a greater degree of credibility is achieved.

However, one downside to grouping class codes, especially when the groups only have a few class codes, is that a single class code with very poor experience can negatively impact the indicated rates of the other class codes in that group. This can be seen to some degree on page 1 of Appendix D, Exhibit 1 of WSI's actuary's 2006-07 analysis. Group 1 consists of 8 class codes. Column C shows that class codes 0007 and 0251 have significantly worse experience than the others in Group 1, and although these two class codes are relatively small, they are negatively impacting the group indication.

For example, comparing class code 0050's ratio to current premium rate of 0.659 to WSI's overall ratio of 0.730 in Appendix C, Exhibit 1, it can be seen that class code 0050 would have an indicated rate decrease if it were rated individually. However, since it is part of Group 1, class code 0050 received a rate increase of 3.7%.

The prior discussion is not intended to imply that the use of groups is inappropriate for WSI. The use of groups to address credibility concerns is an accepted actuarial procedure. (See Recommendation 8.5-g)

CACI concluded that the individual rates by class code meet the criteria outlined in the preceding section. That is, the rates are reasonable and not excessive, inadequate, or unfairly discriminatory.

Methodology Review

The standard actuarial methodology utilized in establishing rates is as follows:

1. Estimate ultimate incurred losses for prior periods.

2. Adjust the losses to the projected period by adjusting for benefit changes and inflation.

3. Compare the losses and expenses to premiums at the current rate level using payroll adjusted for wage inflation.

4. Ratios greater than 1.00 indicate a rate increase is necessary, while ratios less than 1.00 indicate a rate decrease.

The above methodology is the standard approach for insurers and is the approach WSI's actuary uses in determining WSI's indicated rate change. Below each step is analyzed in greater detail to see how WSI's actuary customized the above steps to better fit WSI's circumstances.

The first step in WSI's actuary's procedure for estimating ultimate losses is to segregate the losses into time loss, medical, medical-only, and permanent partial impairment. Losses are segregated in this manner to make the data more homogeneous and to make it easier to apply law and benefit changes from the historical periods to the projected period.

After segregating the losses, WSI's actuary utilizes 6 estimation procedures to derive 6 estimates of ultimate loss for each category. These procedures include incurred and paid loss development, incurred and paid Bornhuetter-Ferguson, and two count/severity methods. The use of multiple estimation methods is appropriate and increases the confidence placed on the selected ultimate losses for each loss type. The methods that WSI's actuary has chosen to use are all standard methods that have been, at least to some extent, customized to WSI's losses. For example, all of the methods rely on WSI's unique historical loss development patterns. From the 6 estimation methods, WSI's actuary selects estimated ultimate incurred losses by accident year for each type of loss. The procedures and selections WSI's actuary has utilized at this step are reasonable and appropriate.

Next WSI's actuary adjusts the ultimate losses to account for changes in benefit laws, wages, and medical costs so that the losses from the historical periods are on the same level as the projection period. Additionally, the historical payroll is adjusted and multiplied by the current rates to develop on-level premiums for each year. These types of adjustments are necessary to project accurate rates for the future. The factors and methodology used by WSI's actuary in this step are appropriate and reasonable.

WSI's actuary notes in both reports that the statewide average weekly wage (SAWW) has generally seen annual changes ranging from 3% to 4%, and that a rate of 3.5% is assumed for the future. However, in Appendix K, Exhibit 2 of the 2006-07 report, it appears that the annual change utilized is 4.0%. The same exhibit in the 2005-06 analysis shows 3.5% as described. The data presented in the two analyses does appear to justify the move from 3.5% to 4.0%.

The next step is to develop loss and expense ratios at the current rate levels. To do this, the ultimate adjusted losses are divided by the on-level premiums and a loss ratio for each loss type is selected. Each selected loss ratio is then adjusted to reflect future investment income earned on the reserves until they are paid. A discount rate of 2.5% is utilized in both analyses;

however, in Appendix A, Exhibit 5, Pages 1 and 2 of the 2005-06 analysis, a discount rate of 3.0% is shown. It does not appear that the resulting discount factors at 3.0% were carried forward, but rather 2.5% discount factors calculated outside of the report. (See Recommendations 8.5-a and 8.5-c)

It is important to note that when establishing rates on a discounted basis, it is assumed that the investment income earned on the loss reserves will be available to pay losses as they come due in the future. If the investment income falls short of what is assumed, the investment income is used for other purposes, or losses are paid out much faster than anticipated, then a shortfall may exist in the future. The conservative interest rate of 2.5% utilized in these analyses makes it less likely that a future shortfall will exist.

CACI would like to point out that the interest rate used to discount loss reserves in WSI's financial statement is 5.0%. This rate is justified in the financial statement based on recent performance and the investing objectives and guidelines of WSI. By using a 2.5% interest rate when establishing rates, WSI is building in a small cushion to account for the factors discussed in the preceding paragraph. (See Recommendation 8.5-d)

Now that the discounted loss ratio has been derived, it is adjusted to account for administrative expenses, experience modification factors, losses in excess of $1,000,000, and backlog in medical payments. These were discussed in the "Overall Rate Appropriateness" section of this report. After all the adjustments are applied, the resulting loss and expense ratio at the current rates is 0.991. Thus, a rate decrease of 0.9% is indicated. As mentioned previously, WSI selected a rate change of 0.0%.

As indicated before, the methodology utilized by WSI's actuary is standard for workers compensation. It has been modified, where appropriate, to better fit with WSI's operations. The selected rate change of 0.0% is reasonable and appropriate given the results of the analysis.

Classification and Rate Benchmarking

As part of this review, CACI has compared the number of classifications and rates to that of similar entities and/or other states. Given the differences in size, industries, benefit levels, laws, and economic conditions between states, such comparisons are often difficult. The size of the state and the types of industries in the state will help determine the number of classifications in the state, while several other factors including the economic conditions, laws, and benefit levels help determine the rate levels.

Turning first to the number of class codes, WSI's actuary calculated rates for 142 class codes in the 2006-07 analysis (151 in the 2005-06 analysis). By comparison, Wyoming, Washington, and Ohio have 121, 317, and 457 class codes, respectively. Each of these states is also monopolistic like North Dakota. Obviously, the state with the most similar economy and size is Wyoming.

Based on these comparisons, it appears that the number of class codes WSI writes is reasonable.

It is important to note that there do appear to be several class codes that could be dropped based on payroll in the last few years. For example, class code 0007 has not had any payroll since the 2001-02 year. CACI counted 8 other class codes with no payroll in at least the last three years analyzed in the 2006-07 analysis. Additionally, there may be a few class codes where payroll is so small that they could be combined with other class codes, such as class code 9180 with only $190,200 in payroll in 2004-05. Note that WSI's actuary's treatment of these class codes is appropriate in that the class codes with little or no payroll are given little or no credibility when deriving rates.

Comparing rates between states is much more difficult. Considerations that must be made when comparing overall industry rates between states include the applicable benefit laws, overall economy, mix of business, and types of industries in the state. That being said, the State of Oregon regularly compares the average premium rates of all 50 states and the District of Columbia. The procedure includes analyzing the largest 50 class codes from Oregon based on losses in Oregon. The rates for these class codes from each state were weighted based on the payroll distributions of the Oregon class codes.

The results from the October, 2006 Oregon analysis indicates North Dakota has the lowest premium rate of any state at $1.10. The median premium rate (the rate at which half the states charge more and half charge less) is $2.48. The highest rate is Alaska at $5.00. Wyoming, Washington, and Ohio are $2.40, $2.17, and $3.00, respectively, which places them 28th, 36th, and 12th, respectively.

As stated previously, interpreting these results is highly dependent on the considerations listed above. The methodology utilized reflects only the mix of business in Oregon for a select group of class codes. The goal of this analysis is to see what Oregon businesses might pay in other states.

As a comparison to North Dakota's $1.10 rate noted above, column K of Appendix I, Exhibit 1, Page 1 of the 2006-07 analysis shows the overall average on-level premium rate (that is the average manual premium per $100 of payroll after adjusting for inflation and rate changes) for the last six years in North Dakota is approximately $2.60. Although these rates are not on the same basis, the comparison is included to illustrate just how difficult such rate comparisons can be and how any such comparison needs to be closely scrutinized.

It is important to note again that the $1.10 rate reflects only the top 50 class codes in Oregon. This mix of business is most likely highly different than the mix of business actually in North Dakota. For example, the top 50 class codes in Oregon probably do not contain an equivalent for North Dakota class code 6203, Oil and Gas Development – Drilling, which has an indicated rate in the 2006-07 analysis of $12.62. Thus, the reason North Dakota's actual average rate is

higher than indicated in the Oregon study is due to different mixes of business, specifically that some of North Dakota's class codes with higher rates were probably not considered in the Oregon study. However, the bottom line in the Oregon study is that using only those top 50 class codes in Oregon, along with the mix of those class codes in Oregon, North Dakota has the lowest rates among all the states. The fact that the overall rate in North Dakota of $2.60 is higher than the median rate from the Oregon study is of little consequence since the rates are on such vastly different basis.

Premium Rebates to Employers

Objective

Determine if the provision of premium rebates to employers is an indication that premium billings are too high. Premium rebates provided to employers in fiscal years 2003-2007 should be reviewed and their effects on WSI's financial position should be disclosed.

Key Activities

To conduct this analysis, BDMP undertook the following activities:

1. Obtained an understanding of the premium rebates issued to policy holders during the fiscal years ending June 30, 2003 through June 30, 2007 through discussions with management and review of Board of Trustee minutes;

2. Obtained the audited financial statements for the fiscal years ending June 30, 2003 through June 30, 2007; and,

3. Obtained listings of the premium dividends issued to policyholders for each of the policy years from June 30, 2004 through June 30, 2007 as of April 30, 2008.

Observations & Findings

The policy dividends have been declared on a prospective basis. At the beginning of the policy year, the policyholders receive a dividend based on the estimated premiums for the upcoming policy year. At the end of the policy year, the dividend amount is settled in connection with the final determination of the net premiums after other discounts. This methodology benefits any employer that is currently receiving workers' compensation coverage through WSI. Per WSI they are now declared on a retrospective basis. (See Recommendation 8.4)

The impact of the policy dividends declared for each of the fiscal years ending June 30, 2003 through June 30, 2007 is as follows (Table 8-3):

Table 8-3: Impact of premium dividends on fund surplus

Policy Year Ended	Date Declared	Dividend Percentage	Dividend	
June 30, 2003	Not applicable	- %	$ -	
June 30, 2004	Not applicable	- %	-	
June 30, 2005	March 4, 2004	5 %	(4,502,320)	(1)
June 30, 2006	June 9, 2005	40 %	(48,269,073)	(1)
June 30, 2007	June 15, 2006	40 %	(51,452,766)	(1)
June 30, 2008	June 7, 2007	50 %	(67,865,170)	(2)
			$ (172,089,329)	

(1) Dividend amounts per detailed listing of premium dividends provided by Management
(2) Dividend amount per audited financial statements for the year ending June 30, 2007

Based on our review of the audited financial statements, the fund balance increased by approximately $80,862,000 during the period of July 1, 2002 through June 30, 2007. The increase in the fund surplus before the dividends in Table 8.3 was approximately $252,951,000. Based on our review of the audited financial statements, WSI incurred operating losses for each of the years ending June 30, 2003 through June 30, 2007. The operating losses incurred by WSI were offset by significant investment income during each of the years ending June 30, 2004 through 2007. A change in the discount rate for the unpaid losses and LAE from 6% to 5% resulted in reduction of the fund surplus in the amount of $55.1 million during the year ending June 30, 2005.

The actuarial process of rate setting is a significant estimate that is dependent on several key assumptions. One key assumption is the rate of investment return that is expected in future years. For the years under review, WSI used an assumed rate of return of 2.5% on investments. The performance on investments exceeded the assumed rate of return over the period of July 1, 2003 through June 30, 2007, which contributed to the increase in the fund surplus.

The change in the fund surplus for the years ending June 30, 2003 through June 30, 2007 is comprised of the following (Table 8-4):

Table 8-4: Summary of audited financial statements from June 30, 2003 through June 30, 2007

	(in thousands) For the Year Ended June 30,				
	2003	2004	2005	2006	2007
Operating revenue	$ 90,747	$ 99,712	$ 106,195	$ 94,383	$ 130,586
Claim awards	(149,136)	(105,132)	(102,385)	(82,973)	(129,355)
Operating expenses	(17,919)	(17,183)	(17,906)	(18,666)	(16,302)
Loss from operations	(76,308)	(22,603)	(14,096)	(7,256)	(15,071)
Investment and other income	80,331	91,358	79,595	39,422	121,020
Increase in surplus before change in discount rate and dividend	4,023	68,755	65,499	32,166	105,949
Change in discount rate	-	-	(55,100)	-	-
Increase in surplus before dividend	4,023	68,755	10,399	32,166	105,949
Dividend expense	-	-	-	-	(67,865)
Increase (decrease) in fund surplus	4,023	68,755	10,399	32,166	38,084
Fund surplus, beginning of year	385,973	389,996	458,751	469,150	501,316
Prior period adjustment	-	-	-	-	(72,565)
Restated surplus, beginning of year	385,973	389,996	458,751	469,150	428,751
Fund surplus, end of year	$ 389,996	$ 458,751	$ 469,150	$ 501,316	$ 466,835

The above information was summarized based on the audited financial statements provided by WSI. We did not perform any auditing procedures to verify the information presented above.

For fiscal years ending June 30, 2003 through June 30, 2006, the dividends declared by WSI's Board of Directors were presented as a reduction of operating revenue in the audited financial statements on a straight-line basis over the coverage period of the underlying contract.

Per Note 2 to the audited financial statements as of and for the year ending June 30, 2007, a "prior period adjustment was made to reflect WSI's current accounting practice for dividends declared by WSI's Board of Directors. Accounting principles generally accepted in the United States of America requires that dividends declared but unpaid are to be recorded as an expense in the current period with a corresponding liability on the balance sheet. Prior to fiscal year 2007 dividends declared by WSI's Board of Directors were expensed in subsequent periods as they were applied to employers billing statements. As a result, a prior period adjustment of $72,564,531 has been made to reduce the fiscal year 2007 beginning Net Assets to properly reflect dividend expense pertaining to prior years."

BDMP utilized the dividend listings for policy years ending June 30, 2007 and 2006 provided by management as of April 30, 2008 to recalculate the prior period adjustment with the results shown in Table 8-5.

Table 8-5: Recalculation of the Prior Period Adjustment for Change in Accounting Policy

Policy Year Ended	Date Declared	Dividend per Listing as of 4/30/08	Recalculated Prior Period Adjustment
June 30, 2006	June 9, 2005	$ (48,269,073)	$ (20,948,964)
June 30, 2007	June 15, 2006	(51,452,766)	(51,452,766)
			(72,401,730)
Prior period adjustment per financial statements			(72,564,531)
Difference			$ 162,801

The initial calculation of the prior period adjustment was based on net premiums estimated at the beginning of the policy year. Any changes in the net premiums that occur as a result of closing out the policy year were not included in the initial estimated prior period adjustment. Any changes in the estimated dividends from the June 30, 2007 and 2006 policy years will be reflected in the financial statements in the fiscal year that the policy year is closed.

Conclusion

While there are many factors to consider in establishing rates for each policy year and with the benefit of hindsight, we believe that the amount of the dividends issued to policyholders is an indication that the rates during the years ending June 30, 2004 through June 30, 2007 were too high.

Premium Rebate Comparison to Monopolistic States and Insurance Companies

Objective

Determine if WSI's rebates to employers is reasonable based on other monopolistic states and large insurance companies (regarded as industry leaders) that specialize in providing workers compensation insurance.

Key Activities

Casualty Actuarial Consultants (CACI) a member of the BDMP project team, performed the analysis for this component of Element Eight

Finding, Analysis and Conclusions:

According to Note 19 of WSI's June 30, 2007 financial statement, "NDCC 65-04-02 requires WSI to maintain adequate financial reserves plus surplus of at least 120% to a maximum of 140% of the actuarial discounted reserve." As of June 30, 2007, the discounted loss reserves were $730.9 million while surplus was $466.8 million, or 63.9% of reserves. The allowable surplus is between $146.2 million and $292.4 million. Thus WSI is carrying $174.4 million more in surplus than allowed by law as of June 30, 2007. (See Recommendation 8.6-b)

In understanding this analysis of WSI's specific surplus situation, it is important to review some of the reasons for maintaining adequate surplus with regards to the loss reserves. The three main reasons for maintaining surplus as of June 30, 2007 with regards to reserves are:

1. Greater than expected development in losses that occurred on or before June 30, 2007. In this case the loss reserves booked as of June 30, 2007 could be insufficient to cover future loss payments.

2. Losses are paid out much more quickly than anticipated when discounting the loss reserves. If the losses are paid more quickly, there will be less time to earn the investment income assumed in the discounting process.

3. The interest rate actually earned is lower than assumed in the discounting procedure. Currently, it is assumed that WSI will earn 5.0% on investments. Should the actual rate of interest be lower, surplus will be required to make up the difference.

Given the nature of workers compensation and the sizeable WSI loss history available, it is unlikely that item #2 poses a significant threat to WSI surplus.

Regarding item #1, CACI has not reviewed the most recent WSI reserve analysis; however page 27 of the June 30, 2007 financial statement does show how the estimated ultimate losses from

the last 10 years have developed over time. While there have been fluctuations from year to year, both up and down, it appears that, overall, the estimated ultimate incurred losses are fairly stable from their initial estimates. In fact, estimated ultimate incurred losses for 1998-2006 have actually decreased a combined 2.45% from each year's initial estimate to its estimate as of June 30, 2007. Of course loss development patterns can change, however it appears that over the last 10 years, estimated ultimate incurred losses have been fairly stable. Further, even if losses from these prior periods were to increase in the future, the increase is not likely to be more than 10%.

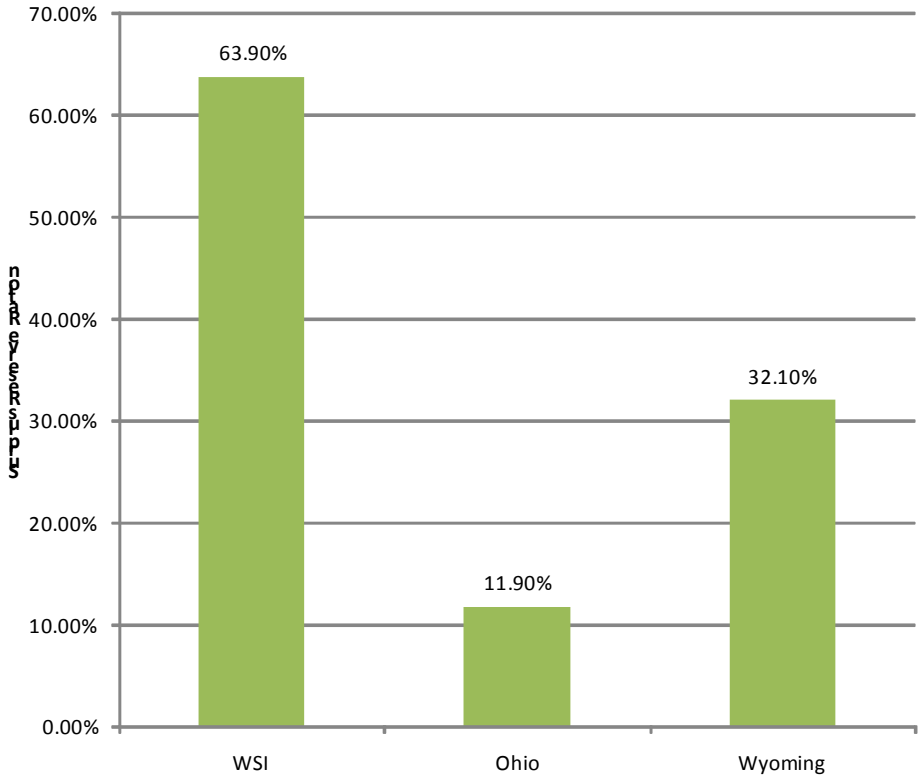
In CACI's opinion, item #3 poses the most significant threat to WSI's surplus. Due to the long-tailed nature of workers compensation losses, a small change in the interest rate assumption can significantly impact the discounted loss reserves. As of June 30, 2007, the discounted reserves were $730.9 million using a 5.0% discount rate and based on undiscounted reserves of $1.2011 billion. Thus, the implicit assumption is that WSI will need to earn $470.2 million in investment income until all losses are paid in order to have enough to cover all future loss payments and not use any current surplus.

In evaluating the specific surplus requirements outlined in NDCC 65-04-02, CACI researched two other monopolistic states to determine their current surplus levels. Although CACI did not find specific surplus requirements, the surplus levels as of June 30, 2007 were available.

Ohio shows total surplus in their workers compensation program of $2.3 billion as of June 30, 2007. Discounted loss and loss adjustment reserves as of June 30, 2007 are $19.3 billion using a 5.0% interest rate. Thus, surplus is currently 11.9% of reserves.

Based on information provided by WSI's actuary, Wyoming's workers compensation program has a surplus of $206.3 million as of 6/30/07. Loss reserves booked as of 6/30/07 total $642.2 million discounted at 3.5%. Therefore, the Wyoming surplus to reserve ratio is 32.1%.

Table 8.6: Comparison of surplus to reserve ratio to Ohio and Wyoming



As mentioned above, neither of these states have a specific surplus requirement. Additionally, there is no industry-wide accepted surplus to reserve ratio. However, NAIC IRIS Ratio #2 compares an insurer's net earned premium and surplus. An exceptional value (that is one outside the acceptable limit that needs to be explained) is created when the premium to surplus ratio is greater than 3.0. If the premium to surplus ratio is greater than 3.0, the insurer is at higher risk for not being able to pay claims. So, according to this standard, an insurer should maintain a premium to surplus ratio less than 3.0. Based on the net earned premium of $128,119,278 in WSI's 6/30/07 financial statement, WSI's premium to surplus ratio is 0.274, well under the acceptable limit of 3.0. The minimum surplus required to avoid an exceptional value over 3.0 is $42.7 million. Thus, using the NAIC IRIS Ratio #2 standard, WSI could have as little as $42.7 million in surplus and still not generate an exceptional value over 3.0 Comparing this minimum surplus of $42.7 million to WSI's current reserves yields a surplus to reserve ratio of 5.84%. Therefore, using this measure of surplus adequacy, the NAIC might consider 5.84% of reserves as the minimum surplus requirement for WSI. (See Recommendation 8.6-a)

WSI's current surplus position is clearly outside of the range allowed by North Dakota law. Additionally, the North Dakota law appears to require, at a minimum, a greater surplus than any of the above three alternative measurements. Further, since the manual rates are calculated utilizing an interest rate of 2.5% rather than the 5.0% rate used to discount the loss

reserves (which WSI assumes to be realistic), then there is an additional small cushion built into the rating structure.

Recommendations

Following are BDMP's recommendations with respect to Element Eight:

Recommendation 8.1: Implement a procedure that provides for a documented review of experience rate changes posted to PICS. (Low)

> We recommend that on a recurring basis, a query is printed to list the policies that have been changed and those changes be reviewed by management for reasonableness of the change and accuracy to verify that the adjustments are appropriate.

WSI Response: CONCUR

WSI will implement a policy requiring all experience rate changes be approved by PHS management prior to updating the experience rate table. Work papers detailing the change will be initialed by the Director of PHS or Underwriting Supervisor and such approval will be documented in the PICS notes.

On a recurring basis, a query will be run listing accounts with changes made to the experience rate calculation. This list will be compared to documentation as recorded in the PICS notes to verify appropriateness.

Recommendation 8.2: The risk based audit plan should incorporate a planned response and follow-up for premium audits with exceptions outside of tolerable ranges. (Medium)

> The current audit plan assigns risk based on the amount of premiums charged by WSI to the policyholders. Policyholders with net premiums between $5,000 to $100,000 are on an audit plan that rotates the planned premium audit on a three to five year basis. We recommend that WSI consider adding documentation to the current premium audit plan related to provide a planned course of action for premium audit adjustments that exceed a certain threshold for policyholders with premiums less than $100,000. These policyholders should be added to the following year's audit plan to determine that the audit adjustment is not a recurring issue. If the following year's premium audit is completed within the tolerable range, the policyholder can be placed on the planned rotation process.

WSI Response: CONCUR

WSI will identify a predefined adjustment amount that when met, will trigger a planned response and follow-up by the premium audit unit. Accounts meeting this criterion will be placed on the following year's audit plan to verify that adjustments have been incorporated into payroll reporting. Those accounts within the predefined adjustment amount will be placed on the scheduled 3-yr or 5-yr rotation basis.

Recommendation 8.3: WSI should formally review the premium audit function and determine whether additional staffing is necessary in order to comply with the stated audit plan. (High)

WSI currently has 8 people performing the premium audits outlined by the current audit plan. Based on the number of premium audits completed through April 30, 2008 compared to the audit plan it does not appear that there is sufficient staffing to comply with the stated audit plan. We recommend that WSI increase the number of hours dedicated to perform the premium audits in order to meet the current premium audit rotation schedule.

WSI Response: CONCUR

WSI recognizes that the stated audit plan exceeds current staffing levels within the Premium Auditor unit. WSI is currently in the process of opening a Premium Auditor position that will be dedicated to performing premium audits.

Recommendation 8.4: WSI should adopt a process that allocates policyholder dividends to active policyholders based on historical information. (High)

As noted in our discussion of element eight, the policyholder dividends have been established on a prospective basis. This methodology is providing dividends to new policyholders in the year that the dividend is declared despite the fact that the policyholder did not contribute to the fund surplus. In addition, the amount of the dividend awarded when it is declared is difficult to estimate. The dividend amount is initially estimated based on the payroll information and safety discounts as of the beginning of the policy year. The final dividend can be significantly different based on changes in payroll levels, employee rate classifications and the amount of claims incurred by the policyholder.

We recommend that WSI establish a procedure to determine the policyholder dividend on a retrospective basis. One potential approach would be to aggregate the net premiums billed to policyholders over the past five to seven policy years. The allocation of the declared dividend amount could then be allocated to the applicable policyholders using a weighted average of the historical net premiums.

WSI Response: CONCUR

Beginning for policy periods July 1, 2008 and subsequent, dividend calculations are being made on a retrospective basis utilizing prior year premium amounts. This alleviates the issue of dividends being awarded to new accounts and fluctuating dividend calculations.

WSI's Board of Directors adopted the change in the allocation base for dividends earlier this year. F/Y 2008-09 dividends will be distributed based on prior year premiums rather than prospective premiums.

Recommendation 8.5: CACI indentified the following observations and recommendations resulting from the overall rate review. These recommendations should help to enhance the understandability of the actuarial report.

a. **Strengthen the overall documentation and discussion in the report. (Medium)**

   In particularly when values are added/removed/changed that directly impact the rate indication. For example, the adjustment for backlog in medical payments was added in 2006-07 with no discussion about what this represents. Additionally, descriptions at the beginning of each appendix or at least at the end of the Analysis section would assist the reader in following the ratemaking process.

WSI Response: CONCUR
There will be additional information in subsequent reports.

b. **Include documentation of losses in excess of $1,000,000 provision in future reports. (High)**

WSI Response: CONCUR
Documentation will be included in future reports.

c. **Disclose the impact of using discounted rates versus undiscounted rates and the effect of funding the Risk Management and Safety Incentive Program from surplus. (Low)**

WSI Response: PARTIALLY CONCUR
WSI will introduce the change recommended by CACI at the direction of the Board of Directors. However, WSI questions the value or need for this additional information (and the additional work that will be required to generate it). A rate level indication derived using undiscounted rates is not particularly relevant to the fund's current pricing structure or financial position.

d. **Document and explain why the discount rates used in the rate analysis (2.5%) and the reserve analysis (5.0%) are different and the impact of this difference on both the reserves and the rates. (Low)**

WSI Response: CONCUR
Documentation will be included in future reports.

e. **PAC should add a range of rate indications to assist the Board of Directors in making rate change selections. (Medium)**

WSI Response: DO NOT CONCUR
The purpose of the rate review report is to document the rationale for the change adopted by the Board of Directors. Discussion of potential ranges is handled before the rate level decision is made. Except in highly unusual circumstances, it is not common insurance industry practice to present indications in the form of a range when submitting a rate filing. Individual insurance carriers tend not to do so. Rating Bureaus in other states tend not to do so.

f. **Document and explain the following from the rate review: (Low)**

- Derivation of the new minimum premium shown in Appendix M;
- Loss ratio of 87% used in Item B;
- The expense provision of $10,600,000 in Item D does not match the expense provision of $11,600,000 in Appendix A, Exhibit 6.

WSI Response: CONCUR
WSI agrees that the documentation included in the rate report could have been more complete. However, the underlying assumptions and calculations were fully documented in a separate set of exhibits presented to WSI.

g. **Group assignments, and possibly other rating steps, should be made in a manner to ensure that the impact of a single class code on the group will be minimized. (Medium)**

For reference, the National Council on Compensation Insurance (NCCI) groups the approximately 600 class codes it rates into 5 industry groups.

WSI Response: CONCUR
WSI acknowledges the validity of the issue raised by CACI. However, WSI is working to introduce a refinement to the class ratemaking process that has the potential to be far superior to the approach recommended by CACI.

Recommendation 8.6: CACI recommends that WSI seek to modify the appropriate section of North Dakota statute to reduce the lower end of the required fund surplus range to 115% of the discounted loss reserves plus surplus. (High)

This change yields a surplus range of $109.6 million at a 115% directed loss reservation which is still higher than both of the other monopolistic states discussed in our findings. Additionally, the resulting premium to surplus ratio at the minimum surplus level is 1.17,

well below the 3.0 limit in NAIC IRIS Ratio #2. CACI observed that the recommended low end of the surplus range is still large enough to cover all but catastrophic changes in the current loss reserve calculation.

WSI Response: PARTIALLY CONCUR

WSI is not in a position to respond or seek to modify at this time. WSI's Board will need to evaluate further and after consultation with the appropriate experts will consider whether they want to pursue this legislatively.

Recommendation 8.7: CACI recommends that WSI request its actuary to provide confidence levels on the range of reserves shown on page 22 of the June 30, 2007 financial statement. (Medium)

Based on the range shown as of June 30, 2007 and the recommended minimum surplus above of $109.6 million, WSI could reserve losses at the high discounted level and still be left with $500,000 in surplus. Confidence levels would help identify the likelihood of losses developing up to and beyond the high loss level.

WSI Response: PARTIALLY CONCUR

WSI's actuary routinely provides estimates of unpaid loss and LAE in the form of a range as part of the reserve review process. WSI does not concur with providing confidence levels as the approach utilized by PAC is commonly used throughout the insurance industry. WSI will introduce the change recommended by CACI at the direction of the Board of Directors.

Element 9: Legal

Objective

Element Nine required a review of the administrative hearing process, including the following areas:

1. Evaluating the efficiency and effectiveness of the overall administrative hearing process and benchmarking the process against other monopolistic states and large insurance companies specializing in providing workers compensation insurance;

2. Evaluating the type and quality of training provided to contracted administrative law judges, and benchmarking this training against that provided by other monopolistic states and large insurance companies specializing in providing workers compensation insurance; and

3. Evaluating how legal staff spent their time during the period covered by the performance evaluation to determine whether appropriate amounts of time and effort were dedicated to WSI's primary functions and responsibilities, and benchmarking the results of this evaluation against similar activities in other monopolistic states and large insurance companies specializing in providing workers compensation insurance.

Key Activities

BDMP performed the following activities to gather information about the administrative hearing process:

1. Reviewed the North Dakota statute and rules pertaining to dispute resolution;

2. Reviewed the process and forms used by WSI and injured workers or employers when they have a disagreement on claim decisions;

3. Reviewed previous audit reports, including the Conolly and Associates report of March 5, 2008, the Marsh claim process review of March 4, 2008; and the Octagon performance evaluation for the previous biennium;

4. Interviewed the General Counsel; two of the three staff attorneys; one paralegal; two claims supervisors; three claims adjusters; the executive support staff handling the administrative law judge contracts and scheduling; the legal services manager within WSI; the manager of the Office of Independent Review (OIR); one contract

administrative law judge; the director of the Office of Administrative Hearings (OAH); a retired administrative law judge; and three injured worker attorneys;

5. Reviewed materials about the North Dakota dispute resolution process, including the Administrative Law Judge Scope of Work; Administrative Law Judge Code of Judicial conduct; various memorandum between WSI and OAH during the biennium; various Statistics on Disputed Cases provided by WSI, OIR, and OAH; training materials used by WSI for administrative law judges; a sampling of case decisions provided by the attorneys, OIR, and WSI; and a legal treatise on the North Dakota Law entitled *Falling Down on the Job: Workers' Compensation Shifts From a No-Fault to a Worker-Fault Paradigm* authored by Dean J. Haas in the 2003 ND Law Review;

6. Reviewed literature on dispute resolution in workers' compensation (see footnotes for references);

7. Reviewed dispute resolution systems in multiple states;

8. Reviewed statistics (where available) from multiple jurisdictions;

9. Held discussions with two industry experts on the use of contract administrative law judges ALJ's for formal hearings; and

10. Reviewed 25 litigated claims with dates of injury between January 2006 and December 2007.

Background

This section provides background information and context on the review of this element with respect to recent changes in WSI's dispute resolution process, available research against which to measure dispute resolution outcomes. It also provides background information on sources used in benchmarking.

Administrative Law Judges: From 1995 to 2006, WSI contracted with the OAH to provide independent fact finders for the dispute resolution process. In 2007, WSI discontinued utilizing the services of OAH and began contracting individually with administrative law judges to serve in the role of independent fact finders. The objective of this change was to reduce the timeline for recommending a decision.

Research on Dispute Resolution: There is little rigorous research on dispute resolution speed and quality in workers' compensation systems. Most of what is known about how to measure dispute resolution outcomes comes from work done by the IAIABC[34] and the WCRI[35]. However,

[34] For years the IAIABC attempted to compare volume, timeliness and resolution rates in workers' compensation jurisdictions, but had little success due to the differences in process and terminology used. Their attempts were

Ballantyne and Mazingo[36] suggest that the following outcome measures are relevant for a workers' compensation system:

- Disposition rate
- Speed of resolution
- Disputants' costs
- Administrative costs
- Participants' satisfaction and perception of fairness

Available research supports the fact that informal mechanisms (e.g., mediation, use of ombudspersons, and early neutral evaluation) tend to resolve disagreements in a timelier and less costly manner for all participants. In addition, informal approaches generally receive high ratings on measures of satisfaction and fairness and help to maintain the employer/employee relationship, which is important in return-to-work as well as a common system goal. Therefore, systems that use informal approaches to dispute resolution tend to be more efficient and effective and, depending on the resolution rate, have fewer cases that go through the more costly and lengthy formal litigation process.

Benchmarking: As of 2008, four United States jurisdictions (including North Dakota) utilized the "monopolistic state fund" model to administer workers' compensation. Therefore, there are few similarly administrated workers' compensation systems against which to benchmark North Dakota. However, regardless of the type of workers' compensation administration program a jurisdiction has chosen, the goals of dispute resolution are the same: to resolve disagreements as quickly and fairly as possible without adding costs to the system. Thus, it is not unreasonable to compare North Dakota's dispute resolution system with any or all of the other systems in the United States and Canada. Even then, North Dakota's dispute resolution system is unique in a number of respects. A comparison with other large payers such as private insurers or non-monopolistic state funds is not meaningful for this element, since none of these organizations are allowed to make "administrative agency" decisions regarding workers' compensation dispute resolution. This is the authority of a separate state agency.

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published in statistical reports which may still be available from the IAIABC. These were discontinued over ten years ago. The WCRI has published a number of studies on dispute resolution systems in the United States. See www.wcrinet.org .

[35] See Ballantyne, Duncan, *Dispute Prevention and Resolution in Workers' Compensation: A National Inventory, 1997-1998*, May 1998, Workers Compensation Research Institute, Cambridge, MA.

[36] Ballantyne, Duncan and Mazingo, Christopher J., *Measuring Dispute Resolution Outcomes,* April 1999; and various Administrative Inventories describing the dispute resolution systems in various states from 1986 to 2007; Workers Compensation Research Institute, Cambridge, MA.

Observations and Findings

Efficiency and Effectiveness of Administrative Hearing Process

Research supports that the most efficient dispute resolution process resolves a dispute in as short a time as possible with as few resources as possible (e.g., through the use of informal resolution processes). North Dakota's dispute resolution process provides two informal opportunities to resolve disputes before entering into more formal processes:

1. A "Request for Reconsideration" generates an internal review of the WSI decision that resulted in the disagreement.

2. A "Request for Assistance" allows OIR to attempt to mediate a resolution between the parties.

Information obtained from a review of case files revealed that 11% of the disputes were resolved after the filing of a Request for Reconsideration (2 of 18). Information from OIR indicates that an additional 21% of the Requests for Assistance for fiscal year 2006 and 13% of requests for fiscal year 2007 resulted in the resolution of the disputed issue(s). The remainder of the disputes filed were either not pursued by the grievant or moved into the formal dispute resolution system.

Figure 9-1 describes the current process for dispute resolution in the North Dakota system.

Figure 9-1: North Dakota Dispute Resolution Process

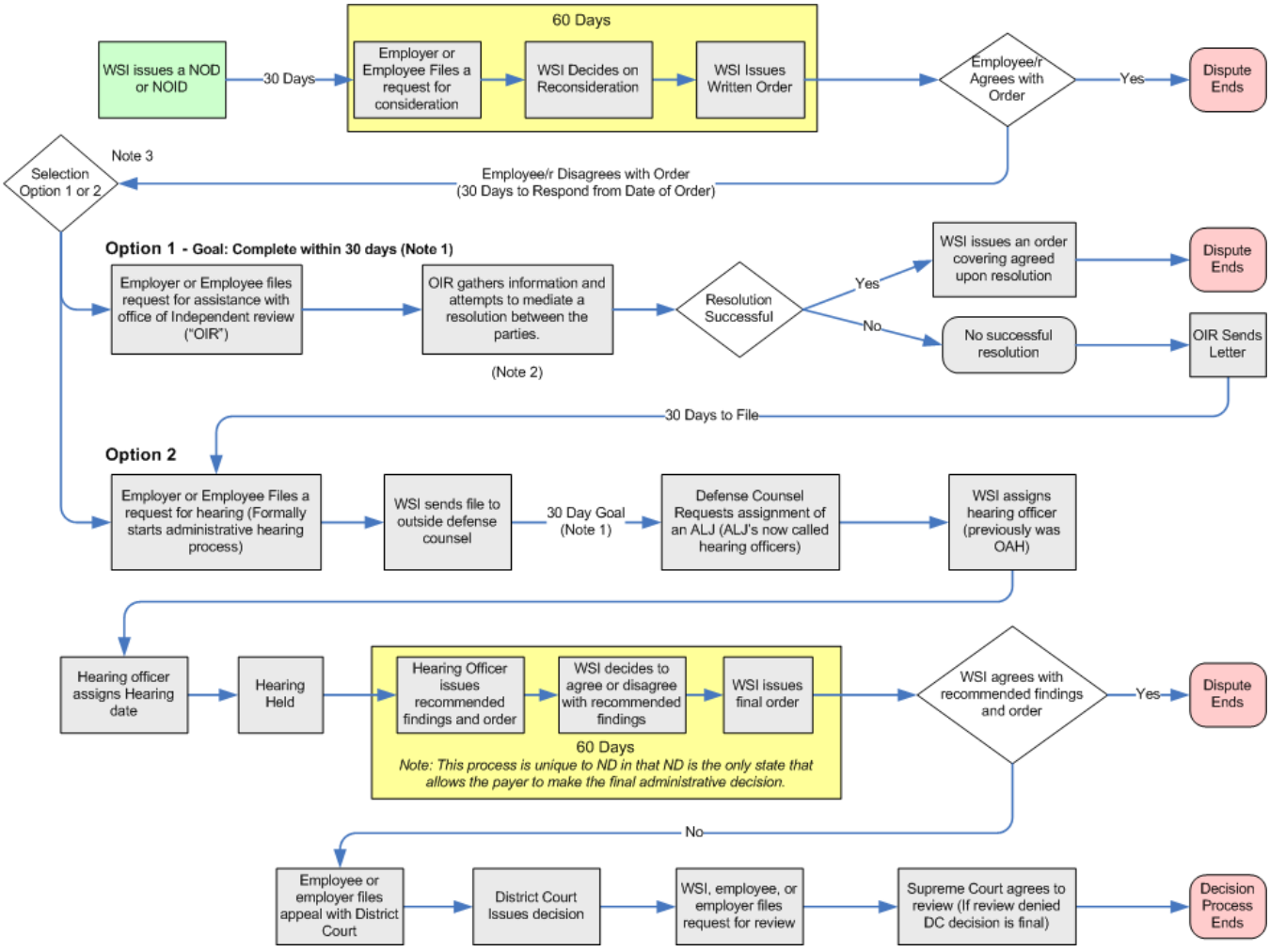

Figure 9-1 Notes:

1. See Stipulation and Order dated 7/25/01 in the matter of Hennen v. North Dakota Workers Compensation Fund

2. There were no OIR records or documents in the WSI claim files. Separate statistics were obtained from OIR about the timeliness of their process. The overall time frame for the ND dispute resolution process can be measured without these specific dates as any disputes resolved with the assistance of OIR would still have a WSI order issued to document the result.

3. Disputants have an option to file a request for assistance with the Office of Independent Review or to file a request for hearing immediately. Most file a request for assistance because if they skip this step, they will not have their attorney's fees paid by WSI if they prevail.

Table 9-1 presents the average timeframes for the dispute resolution process in North Dakota, based on BDMP's review of case files.

Table 9-1: Average Timeframes for North Dakota Dispute Resolution Process

Dispute Resolution Process Pieces	# of days	# of cases[37]
Average time from WSI decision to request for reconsideration	29	17
Average time from request for reconsideration to WSI order	52.5	18
Average time from WSI order to request for hearing	64.3	15
Average time from request for hearing until request for ALJ/Hearing Officer assignment	27.6	15
Average time from request for assignment to assignment of ALJ/Hearing Officer	4.3	15
Average time from assignment to date of hearing	158	11
Average time from date of hearing to recommended decision	54	8
Average time from recommended decision or resolution to WSI order	53.5	11
Total days from request for reconsideration to final resolution:	**295.2**	**12**
Total days from request for hearing to final resolution:	**215.8**	**9**

[37] Of the 25 randomly selected litigation files, three were subrogation files; three had legal expenses but no actual dispute that went through the dispute resolution process; and one had multiple disputes and was eliminated from the audit group because we were unable to calculate which disputes were going through which parts of the process. Therefore, a total of 18 cases with disputes were audited by BDMP.

Table 9-2 provides a comparison of BDMP's findings with data provided by WSI and OAH (where available).

Table 9-2: Comparison of BDMP's Findings with WSI and OAH Data38

Dispute Resolution Process Pieces	BDMP	WSI[39]	OAH[40]
Average time from WSI decision to request for reconsideration	29	n/a	n/a
Average time from request for reconsideration to WSI order	52.5	27	n/a
Average time from WSI order to request for hearing	64.3	n/a	n/a
Average time from request for hearing until request for ALJ/Hearing officer assignment	27.6	22	n/a
Average time from request for assignment to hearing date	162.3	126.2	132
Average time from date of hearing to recommended decision	54	70	50.2
Average time from recommended decision or resolution to WSI order	53.5	22.2	n/a
Total days from request for reconsideration to final resolution:	**295.2**	**n/a**	**n/a**
Total days from request for hearing to final resolution:	**215.8**	**240**	**n/a**

In comparing North Dakota's data with other jurisdictions, we found that jurisdictions use differing terminology and follow unique processes that may or may not align with North Dakota's processes. Therefore, it was difficult to find meaningful comparable data for the timeliness of dispute resolution with other jurisdictions. However, comparisons of the time from the filing of a document that begins the formal administrative hearing process to the time of an issuance of a final award provides some indication of the timeliness of WSI's process. Comparative data is provided in Table 9-3.

[38] The purpose of the table was not to audit WSI or OAH's figures, but to demonstrate that variation is not unique in these measures, depending on which claims you use to measure the results, the date you actually do the evaluation and the fact that the actual dispute resolution process for the worker is much longer than simply the formal dispute resolution process. The number of claims reviewed by BDMP for this element would not be representative of all disputed claims, but was the number of claims required to be reviewed according to the Request for Proposal.

[39] Average time from request for reconsideration to order is taken from "average days-legal order processing in formation" provided by the head of Legal Services and the remainder of the data is taken from six-month totals January to September 2007 provided by the General Council's office.

[40] See 11/16/07 memorandum from the Director of OAH to the State Advisory Council for Administrative Hearings (figure used was stated as that for 2007).

Table 9-3: Comparative Data with Benchmark Jurisdictions

Jurisdiction*	Litigation Rate		Formula Used	Days from Dispute Filing to Final Order	
	2006	2007		2006	2007
British Columbia	Not calculated	3.2%	Estimated from the number of WCAT decisions issued divided by the total claims filed	180 days is statutory requirement	180 days is statutory requirement
North Dakota	1%	1%	Litigation filed divided by the total claims filed	285[41]	240[42]
Ohio	15.6%	15.5%	Hearings divided by claims with activity (this probably means lost time claims are the denominator and therefore, not comparable)	139 days[43]	Not yet available
Oregon[44]	3.8%	Not yet available	Requests for hearing divided by accepted disabling claims.	217	Not yet available
Washington	2.2%	2.3%	Appeals filed to the Industrial Insurance Appeal Board divided by the number of claims filed	240.8	245
Wisconsin[45]	4.97%	4.67%	Estimated from the number of applications for hearing divided by the estimated number of claims filed	Estimated at 315 days	Estimated at 174 days
Wyoming	Not available	Not available		365 (goal)	365 (goal)[46]

* Comparable information was not publically available for Minnesota as of the date of this review, so Minnesota was excluded from this table.

North Dakota's dispute resolution and administrative hearing systems are efficient. This conclusion is based on the following:

- WSI uses two levels of informal dispute resolution to reduce the numbers of disagreements going into a formal and more expensive administrative hearing process;
- WSI has fewer disputes that enter the administrative dispute resolution system than comparable jurisdictions (as measured by the litigation rate); and

[41] Taken from WSI "6 month totals" January – June and July- Dec. 2006; net elapsed days from Req for Hrg to Final Order Issued.
[42] Taken from WSI "Case Chronology 4" January – September, 2007.
[43] Per data from Industrial Commission Statistical report for 2006 found at www.ohioic.com .
[44] Obtained from their publication entitled *Hearing Division Statistical Report for Calendar Year 2006,*published March 2008.
[45] Calculated from data provided by Lee Shorey, Wisconsin Workers' Compensation Division in phone conversation on 6/16/08.
[46] This is the goal for the biennium beginning July 1, 2008. The actual measure they have been using that is comparable to ND's administrative determination process in workers' compensation is time from close of hearing to decision by OAH. This was about 87 days on average for 2006 and 88 days on average for 2007 per the report available at http://oah.state.wy.us/OAH%20Final%20Strategic%20Plan.pdf .

- WSI has resolved cases in the administrative hearing process as quickly as most other jurisdictions.

Of note in this area of performance is a goal of previous WSI management to complete the administrative hearing process (from date of assignment of an Administrative Law Judge to decision date) within 60 to 80 days in most cases.[47] According to the judges and the attorneys interviewed, this is not a realistic goal. Currently, most hearings are scheduled approximately 8 to 16 weeks from the date of the scheduling call, as this is what fits most conveniently into both the defense and plaintiff attorneys' calendars. BDMP also learned that many of these scheduling delays are driven by the WSI defense attorneys, since about 50% of the cases are *pro se* (meaning the injured workers are representing themselves); injured workers are usually motivated to schedule their hearings as soon as possible, especially if they are not currently receiving benefits.

Though many of the delayed hearing dates (ones that have to be rescheduled one or more times) are at the request of the WSI defense attorneys, there are many reasons why a case may not be ready to proceed to hearing. While some of this may be within the control of the Administrative Law Judge or Hearing Officer, if the parties agree to a continuance, generally it will be allowed by the fact finder, who needs to be sure both parties have enough time to present their cases appropriately. The portion that the Administrative Law Judge or Hearing Officer has control over is the time from the hearing (or close of the hearing if additional information is to be submitted for the judge to consider) to the decision they render. In most jurisdictions the standard for this is 30 days.

Effectiveness of Administrative Hearing Process

The second evaluation criterion for the dispute resolution process was one of "effectiveness." In the context of the administrative dispute resolution system, this would usually refer to how *fair* and *unbiased* the system is perceived to be and whether or not the parties felt they had a chance to "tell their side of the story" effectively. Many jurisdictions provide feedback questionnaires or survey both parties to a dispute to determine the perceived fairness of the process.

Based on our review of litigated WSI claim files, interviews with system participants, and comparisons with other jurisdictions, WSI's formal dispute resolution system ranks low in the area of effectiveness. The following points summarize key findings from our review:

1. North Dakota is the only jurisdiction in the United States that allows the payer to make the final administrative decision in disputes between payers and the injured workers or employers. In all other jurisdictions, another public agency or another branch of the executive agency is responsible for issuing a decision, which is then appealable by the

[47] See email from Sandy Blunt to Jodi Bjornstad.

payer, employer or the employee. This can create the perception that final administrative decisions issued by WSI are biased toward the employer.

2. Table 9-4 provides a comparison of North Dakota's decision-making process to three other monopolistic workers' compensation systems, British Columbia, and the states of Minnesota, Oregon, and Wisconsin—three of the "best in class" jurisdictions. Each of the comparative jurisdictions requires the employer/insurer and the injured worker to resolve their differences through an administrative hearing process that acts as a separate operating agency. This structure ensures that disputes are resolved by an independent and impartial hearing authority with no agency interest in the substantive issues presented in the cases it hears.

Table 9-4: Comparative Administrative Hearing Decision-Making Process

Jurisdiction	Payer(s) within the WC System	Agency Responsible for Final Administrative Resolution	State Agency Responsible for Final Decision
British Columbia	Provincial Fund Only	Workers' Compensation Appeal Tribunal	B.C. Ministry of Labour and Citizen's Services
Minnesota	Private Insurers, Self Insurers and State Fund	Office of Administrative Hearings	Office of Administrative Hearings
North Dakota	WSI	WSI	WSI
Ohio	Monopolistic State Fund and Self Insurers	Industrial Commission of Ohio	Industrial Commission of Ohio
Oregon	Private Insurers, Self Insurers, and State Fund	Hearings Division	Workers' Comp Board of the Dept. of Consumer & Business Services
Washington	Monopolistic State Fund and Self Insurers	Industrial Insurance Appeals (IIA)	Department of Labor and Industries – Industrial Insurance Appeals
Wisconsin	Private Insurers and Self Insurers	Division of Workers' Compensation	Department of Employment and Industrial Relations
Wyoming	Monopolistic State Fund and Self Insurers	Office of Administrative Hearings	Office of Administrative Hearings

3. WSI contracts directly with attorneys to act as "independent fact finders" in disputed workers' compensation cases. Without exception, injured worker attorneys, hearing officers, and administrative law judges interviewed had concerns about the perceived fairness of this process, including the potential for WSI to hire fact finders that may have a

bias that would benefit WSI and the belief that individuals hired by WSI to issue decisions cannot maintain complete objectivity.

However, the issue of potential fact-finder bias is of lesser concern from an effectiveness perspective (since their decisions are only "recommended" findings of fact and decisions) than the fact that WSI has the authority to make the final administrative decision on workers' compensation cases and they have an inherent interest in the outcome.

BDMP found no indication of impropriety or inappropriate influence of decisions made by ALJ's or hearing officers, however, the perception of fairness and overall effectiveness of the system could be improved by shifting the role of independent fact finder out of WSI's authority and allowing the independent fact finders' decisions to be final but appealable to the District Court.

4. Many of the system features combine to reduce the opportunity for the injured worker to properly prepare to present his or her case, and create the perception of a system that favors WSI. For example:

   - Injured workers must comply with specific timeframes or they will lose their ability to pursue their case; however, there are relatively few statutory timeframes in which WSI needs to comply or lose their ability to defend their decision.

   - Employees frequently have little knowledge of how to document and prove their cases (e.g., understanding burden of proof and obtaining appropriate medical testimony and evidence). Further, the availability of qualified lawyers in North Dakota to represent injured workers is limited.

   - Injured workers' attorney costs for litigation expenses such as depositions and independent medical evaluations are not recoverable unless they appeal—even if the injured worker prevails at the administrative hearing. Conversely, WSI has resources to document and prove its cases, including internal legal staff, contract attorneys, and independent medical examination physicians in multiple states.

Type and Quality of Training Provided

During the period of this performance review, training for administrative law judges was coordinated by OAH in 2005 and 2006 and by WSI in 2007. Training was provided by several sources, however, these were not necessary impartial sources (WSI, workers attorneys). A limited number of judges received additional training from the National Judicial College. The current training program was factual and provided information on issues a new hearing officer would need to know. However, by involving WSI personnel in the training process, the perception of fairness has been questioned since WSI is a party in most of the cases that will

come before these individuals. A more objective approach would be to hire qualified trainers who have been deciding workers' compensation cases as independent fact finders.

The training provided to administrative law judges was found to be lacking in specific subject matter expertise relative to workers' compensation. Most jurisdictions included in our fact-finding process hire administrative law judges who are experienced in workers' compensation defense or plaintiff work. Conversely, we found that there are very few attorneys in North Dakota who are knowledgeable in workers' compensation law. In fact, according to WSI, one of the reasons the organization initially decided to contract service to OAH in 1995 was because they were having a difficult time finding attorneys with workers' compensation knowledge to be hearing officers.

If attorneys are hired who already understand the workers' compensation statute and case law, they only need to be trained in administrative legal procedures and practice. Such training is available through the International Association of Industrial Accident Boards and Commissions Judicial College or the National Judicial College. For those attorneys without workers' compensation expertise, additional training is needed to adequately prepare the attorneys for their work.

Staffing

In 2005 and 2006, WSI's Assistant Attorneys General spent two-thirds of their time on managing disputed claims. Paralegals spent almost 100% of their time on preparing claims awards. Both of these figures are considered appropriate amounts of time and effort.

In 2007, the following events took place that impacted WSI's legal services team's ability to dedicate an appropriate amount of time and effort to the Division's primary functions and responsibilities:

- Indictment of a number of WSI executives and the resulting open records requests and legal activity related to and subsequent to this occurrence;
- The resignation from, or the elimination of, a number of management positions, necessitating that legal staff fill in as temporary unit managers ; and
- A shortage of paralegals, due to one promotion and the need to reassign another paralegal to work on the design of a new computer system;

As a result of these events, the issuance of awards in 2007 took considerably longer than the average time in 2005 and 2006. However, interview subjects see this as a temporary issue that will resolve itself when the open paralegal and management positions are filled.

Conclusions

As a result of its analysis of the WSI administrative hearing process, BDMP arrived at the following conclusions:

1. *Efficiency and Effectiveness of Administrative Hearing Process:* North Dakota's workers' compensation dispute resolution system has a low litigation rate in comparison with other states, as measured by the number of litigation requests as a percentage of total claims filed (1% for 2006 and 2007)[48]. They use informal means to resolve many of the disputes filed and when issues move into the more expensive formal dispute resolution system the time from hearing to final order is similar to other jurisdictions (about 220 days, or 7.3 months on average from request for hearing to final order issued[49]). This leads to the conclusion that the administrative hearing process is *efficient*.

   North Dakota is the only jurisdiction in the United States that allows the payer to make the final administrative decision in disputes between payers and the injured workers or employers. In all other jurisdictions, another public agency or another branch of the executive agency is responsible for issuing a decision, which is then appealable by the payer or the employee or employer.[50] The payer (WSI in this instance) making the final administrative decision can create the perception that decisions issued by the payer (WSI in this case) are biased in the payer's favor. Further, WSI's process of contracting with attorneys directly to act as "independent fact finders" in disputed workers' compensation cases is perceived as being unfair and potentially biased, therefore, the administrative dispute resolution process used in North Dakota is not be considered *effective*.

   In our work, no indication of impropriety or inappropriate influence of decision was found. However, the perception of fairness and overall effectiveness of the system could be improved by separating the independent fact finder responsibilities from WSI completely and allowing those decisions to be final but appealable to the District Court. This would require statutory changes to make the administrative law judge or the hearing officer's decisions final and appealable by either WSI or the injured worker to the District Court. By eliminating WSI's review of the recommended findings of fact, decision and their issuance of a final order, the dispute resolution process would be

[48] Calculated from WSI "Quick Facts" found at http://www.workforcesafety.com/library/documents/other/QuickFactsFigures.PDF . If you calculate litigation rate by the number of request for reconsideration requested as a percentage of all claims filed the result is 5.6% for 2006 and 6.3% for 2007.

[49] See WSI *Chronology from 1/2005 to Current* on statistics by claim number on times from request for hearing to record closure.

[50] Ballantyne, Duncan, *Dispute Prevention and Resolution in Workers' Compensation: A National Inventory, 1997-1998,* 1998, Workers Compensation Research Institute, Cambridge, MA; and current dispute resolution information from the jurisdictions of British Columbia, Minnesota, North Dakota, Ohio, Oregon, Washington and Wisconsin.

reduced by an average of 22 to 54 days and require fewer resources, thereby making the process even more efficient.

By asking an independent, impartial authority to make the final administrative decision, the process would be considered fairer, more objective, and therefore more effective. This may also encourage WSI to resolve claims earlier in the process, and may change the end agency presumption that currently favors WSI at the appeal level since the end agency action would not be that of WSI, but that of another agency. (See Recommendation 9.1)

2. *Type and Quality of Training Provided:* WSI's training for Administrative Law Judges and Hearing Officers was found to be factual. However, much of the training was provided by WSI employees, which can create the perception that the training is not objective. We conclude that training would be strengthened if it were provided by qualified individuals that are independent of WSI.

   This training also appears to be objective and appropriate, but not sufficient for attorneys with no workers' compensation or administrative law background. An investment should be made in developing a training program on the workers' compensation statute and case law and delivered by an independent trainer (e.g., a retired administrative law judge or a local law school). In addition, WSI should invest in training for Administrative Law Judges and Hearing Officers to attend one of the two national training programs—the National Judicial College or the International Association of Industrial Accident Boards and Commissions' Judicial College. (See Recommendation 9.2)

3. *Staffing:* Due to internal staffing shortages and issues beyond their control during 2007, legal staff members were required to spend less time on their primary functions and responsibilities, which caused a delay in the issuance of claims awards for that year. This should be a temporary situation that will resolve once replacement staff have been hired and trained for the management positions they were filling at the time of the review. In the meantime, WSI may want to consider using claims staff and/or contract attorneys to assist in the dispute resolution processes. (See Recommendation 9.3)

Recommendations

Recommendation 9.1: WSI and the North Dakota Legislature should seek legislative revision of the administrative dispute resolution process so that each final administrative decision is made by an independent, impartial hearing authority from an operating agency separate from WSI. (High)

WSI Response: PARTIALLY CONCUR
Title 28 of the North Dakota Century Code encompasses the Administrative Agencies Practices Act which applies to all state government entities. As noted in the recommendation, the final administrative decision **should** be made by an independent, impartial hearing authority separate from WSI. In part, this is being done.

Effective the 1st of August 2008, the responsibility for providing Administrative Law Judges to preside over administrative hearings requested by aggrieved claimants of WSI decisions has been turned over to the Office of Administrative Hearing, an independent state agency tasked with providing those services to state agencies. By placing the WSI dispute resolution hearing process back to the Office of Administrative Hearings, we believe the perception issues are minimized.

In addition, under the Act, "If the agency head, or another person authorized by the agency head or by law to issue a final order, is not presiding, then the person presiding shall issue **recommended** findings of fact and conclusions of law and a **recommended** order within 30 days after…" N.D.C.C. section 28-32-29(3). We think it is important to point out that this is a legislative issue which could potentially affect WSI and other state agencies, boards, bureaus, commissions, departments, or other administrative units of the executive branch of state government subject to the Act.

However, because WSI currently reverses recommended decisions so infrequently, legislation proposing that final decisions be issued by an entity other than WSI may be worth considering. This issue will be brought before the full Board for its consideration.

BDMP Concluding Remarks
BDMP commends WSI for agreeing to have the office of administrative hearings issue recommended findings of fact and conclusions of law, but believes that as long as WSI continues to be the final administrative authority the perception of bias will remain.

Recommendation 9.2: Train Administrative Law Judges or Hearing Officers, using external experts in both North Dakota workers compensation and the administrative legal process. (Medium)

WSI Response: CONCUR
Since the Administrative Law Judge (ALJ) function has been moved to the Office of Administrative Hearings, that office is responsible for and provides for necessary training related to both the administrative legal process and workers' compensation. WSI will bear some of the training expenses associated with this training, but OAH takes full responsibility for providing this training and sees it as their responsibility to their ALJs. In addition, objective North Dakota workers' compensation experts, as a practical matter, are difficult to find.

Recommendation 9.3: WSI should consider temporarily involving claims analysts to temporarily assist in preparing orders and contracting with WSI's defense attorneys to review and sign off on awards in order to eliminate current delays in the administrative hearing process. (Medium)

WSI Response: CONCUR

This issue has been resolved since your visit with us. Paralegal staffing has been adjusted and we hope to add a staff attorney soon. The administrative order workload is under control and our numbers and timelines are in a satisfactory range.